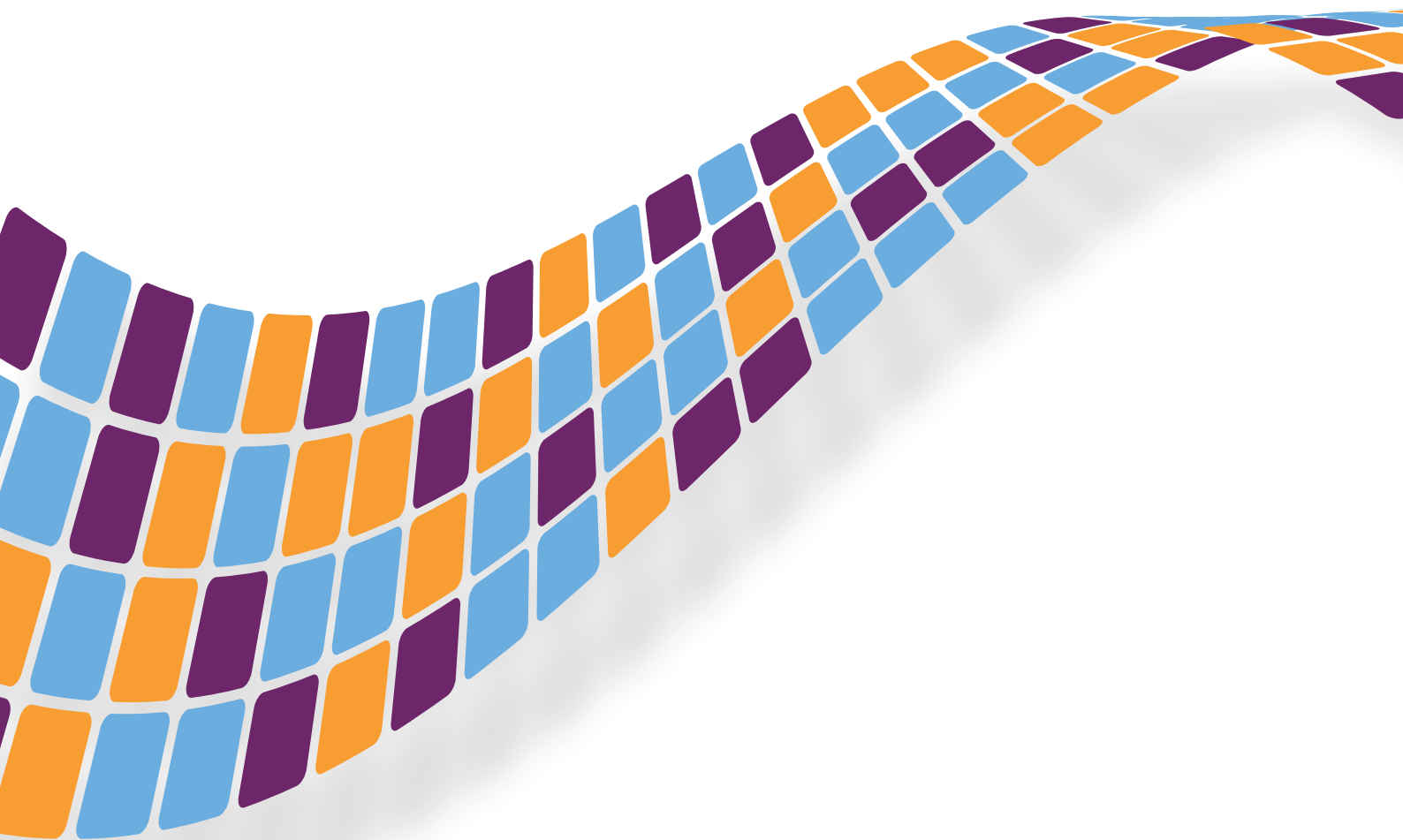




# Monitoring the Mental Health Act in 2011/12





Care Quality Commission

# Monitoring the Mental Health Act in 2011/12

Presented to Parliament by the Secretary of State for Health pursuant to section 120D(3)  
of the Mental Health Act 1983



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# Foreword

## **This Mental Health Act annual report is focused firmly on dignity, involvement, care and the recovery of people who are subject to the Act.**

We live in an age when, rightly, care is delivered around the particular needs of individuals: this is the foundation stone of the current national policy framework in health and social care. CQC sees inspiring examples of compassionate person-centred care on its visits to detained patients. However, we also see evidence of practices and attitudes at all levels of some mental health service organisations that are neither informed by nor respectful of individual rights and needs. We continue to challenge such clearly unacceptable practice where we find it.

This year we have deliberately engaged a wider group of people in the development of this report. We are grateful to the experts by experience and professional experts who have helped us. The report has been greatly strengthened by their willingness to contribute expertise and their consistent reminders that the experiences of people in vulnerable circumstances are at the heart of this work. We would also like to acknowledge the commitment and contribution to this work made by all CQC's Mental Health Act Commissioners and Second Opinion Appointed Doctors through their visits to detained patients.

2012 was marked by some important publications relating to CQC's work that have particular relevance to our Mental Health Act responsibilities. The Serious Case Review into the abuse scandals at Winterbourne View raised questions about the use of mental health

legislation, most particularly when voluntary patients become detained patients. The recommendations of that report reminded us that the treatment of those who are detained under the Act should be focused on recovery and support, with a view to enabling people to return to their local communities as soon as possible. There are strong messages here for both providers and commissioners of services where people are detained.

We are very pleased that the National Implementation Framework for the mental health strategy – also published in 2012 – recognises the significance of the findings in CQC's annual Mental Health Act reports in informing the local priorities of service providers and commissioners.

CQC's report on its inspections of services for people with a learning disability, published in June 2012, raised concerns about the use of restraint and seclusion. CQC has done further work this year to analyse the findings from these inspections alongside evidence from our 2011/12 visits to patients detained under the Act. We publish some of these findings in this report. The work collectively highlights a range of concerns about the enduring use of institutionalised or blanket rules in services for people with specific needs relating to mental health or mental capacity. This is not acceptable. Control and containment must not take precedence over care and treatment.

We are doing further work in our current cycle of MHA visits to shine a light on this issue but there are wider responsibilities here too. We recognise that the solutions will require collaboration, vigilance and action across the system.

Our recent public consultation on CQC's strategy asked for views on how we can strengthen use of the full range of our powers to meet our unique responsibilities on mental health and mental capacity. We have been encouraged by the lengths people have gone to share their experiences and views with us. We have heard some very clear messages about involving more people who use services in our MHA visits, working alongside other national organisations as strategic partners, making better use of information, and making more effective use

of our wider role in quality regulation and our enforcement powers to achieve improvements in the treatment of people subject to the Act.

Above all, we have heard over and over again about the importance attributed to the safeguard that we provide by visiting people who are detained. We are committed to continuing and improving these visits. In the coming year we will be taking these ideas forward, following publication of our strategy in the Spring.



**David Prior**  
Chair



**David Behan**  
Chief Executive

# Summary

**This is the third annual report by the Care Quality Commission (CQC) on its monitoring of the use of the Mental Health Act 1983.**

Mental health is a major issue for this country. Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder, compared to 16% for cancer and 16% for heart disease. Mental disorder has a broad range of impacts across health, education, work and criminal justice as well as links with health risk behaviour and associated premature mortality.

Mental health is high on the Government's agenda. In 2011, the Government stated its commitment to parity of esteem between mental and physical health services in its mental health strategy, No Health without Mental Health. This commitment has been reaffirmed recently in its mandate to the NHS Commissioning Board for the next two years, which legally requires the Board to pursue the objective of putting mental health on a par with physical health. The Government's consultation on the NHS Constitution proposes amending the first guiding principle on the purpose of the NHS to explicitly include mental as well as physical health. The mid-term review, published in January 2013, includes improving the treatment and care of people with mental illness in its four key priorities for health and care.

CQC has a duty under the Mental Health Act (the Act) to monitor how services in England exercise their powers and discharge their duties in relation to individuals who are detained in hospital under the Act, or subject to community treatment orders (CTOs) or guardianship. The primary purpose is to protect the rights of people who are subject to the powers of the Act, and to review the use of legal powers of compulsion. This is the one area of health care

where individuals are deprived of their liberty and treatment can be imposed on an adult without his or her consent. The Act recognises that this is necessary and appropriate for some people, but that it is crucial there are meaningful safeguards against misuse of its powers.

The duties that are placed on the CQC under the Act are different to the other regulatory responsibilities under the Health and Social Care Act 2008, where its focus is to register and inspect the quality of services. The work under the Mental Health Act ensures that individuals receive care and treatment that supports their basic human rights.

These two sets of powers relate to one another as the CQC uses the evidence that it collects in its MHA monitoring to help it judge whether providers are meeting the broader national standards of quality and safety and take enforcement action where necessary.

## **Monitoring how the Act is used: CQC visits to detained patients**

The CQC's visits are made by Mental Health Act (MHA) Commissioners. Importantly, they meet with detained patients and talk to staff on their visits. MHA Commissioners also carry out specific checks on patient documents, the ward environment, and staffing and patient numbers (to ensure the proper care and welfare of detained patients). CQC analyses the information provided by these checks. This analysis has supported production of the data presented in this report.

In 2011/12 MHA Commissioners visited 1,546 wards where patients were detained under the Act, met in private with 4,569 detained patients and checked over 4,500 detention documents

The CQC is also responsible for appointing Second Opinion Appointed Doctors (SOADs)



to check that, where certain treatments for mental disorder are being proposed, without a patients' consent, such treatment is appropriate. In 2011/12, SOADs completed 8,882 visits to detained patients and 3,239 visits to CTO patients.

In this report CQC has cross checked the findings of MHA Commissioner visits, the concerns of service users and professional stakeholders, and policy issues that are relevant to its role in protecting the rights of people who are subject to the Act in England.

To help with this, CQC established an advisory group of service users and external stakeholders. It also had consultation meetings with MHA Commissioners and with members of its Service User Reference Panel.

## What we found: Key messages

The overarching theme of the report is how to embed dignity, recovery and participation in practice when people are subject to compulsory care and treatment. Separate chapters focus on the use of the Act, participation and respect, coercion in practice, care pathways, consent to treatment and CTOs.

CQC's analysis shows that the context for its findings on the experience of people detained under the Act is one in which:

- **The number of people subject to the Act is rising** (those detained as inpatients and those subject to CTOs).
- **Services are under pressure** (for example issues relating to provision of Approved Mental Health Professionals and transport to hospital, high bed occupancy, increased workloads, access to psychological therapies).

What we found:

- **Some hospitals and wards are doing a very good job in treating patients with dignity and respect.** The report highlights good practice, for the first time naming the relevant providers in order that they may share good practice and learning.

- **CQC found some overall improvement but most of the concerns highlighted in previous reports remain**, particularly in respect of care planning, patient involvement and consent to treatment. For example, 37% of care plans checked by CQC showed no evidence of patients' views; there was no evidence that patients had been informed of their legal right to an Independent Mental Health Advocate (IMHA) in 21% of records reviewed; almost half (45%) of patient records reviewed still showed no evidence of consent to treatment discussions before the first administration of medication to a detained patient
- **There is a significant gap between the realities CQC is observing in practice and the ambitions of the national mental health policy** – No Health without Mental Health.
- **CQC is concerned that cultures may persist where control and containment are prioritised over the treatment and support of individuals.** In this kind of culture, 'blanket rules' can become institutionalised. On one in five visits, CQC expressed concern about the de facto detention of patients who were voluntary rather than compulsory patients.

## Conclusions: CQC's recommendations and next steps

The priority given to mental health by the Government will be helpful in raising the profile of these issues and bringing a new impetus to the development of services in ways that reflect the vision of No Health without Mental Health.

The implementation framework for the national policy gives clear guidance to commissioners and providers of services on the actions that will support the expression of this vision in practice. NICE guidelines give further advice in relation to the treatment of specific conditions as well as the involvement of service users in their care and treatment. The policy context, with supporting evidence base, expects that people will recover from mental ill health and that people will be involved in decisions about their treatment. This

holds true for detained patients as much as it does for others. Where an individual's mental health problems persist, reasonable adjustments will be made in all relevant settings, under the requirements of equalities legislation, to ensure that people are supported to live as full and socially participative lives as possible.

Many of the findings and messages in this report are familiar from previous years. It is with great regret that CQC notes that there are themes that recur year on year and paint a picture of practice in some areas of mental health provision that is a far cry from the policy vision. Yet, it is clear from the excellent practice that CQC observes in some providers, that the policy vision is not an unrealistic one. These examples of excellent practice are important in highlighting what can be done and what organisations who fail to provide good care could do.

CQC therefore intends to strengthen the priority it gives to the regulation and monitoring of mental health services in the coming year. Mental health services must address the practice implications of parity and the recovery ethos enshrined in national policy. In particular CQC expects to see change in the following areas of recurring concern in the care and treatment of people subject to the Act:

1. **Care planning should have clear statements about how a person is to be helped to recover, and follow guidance set out in the national Care Programme Approach. Plans should focus on individual needs and aspirations, involving patients at all stages so as to reflect their views and individual circumstances.** Care planning should be multidisciplinary. CQC recognises that on occasion treatment and care decisions can not always reflect what the patient wants. However, within these constraints, every effort should be made by providers to involve people in their own care, treatment and recovery. From a patient's position there should be "no decision about me, without me".

2. **Hospitals should continually review their policies, procedures and practice to ensure there are no 'blanket rules' that cut across treating each person as an individual with rights to autonomy and dignity.**
3. **Clinical staff must be appropriately trained in assessing and recording whether the patient has mental capacity to make decisions and whether they consent to treatment. Ongoing dialogue with the patient is essential.** This conversation or dialogue should consider what treatment a person prefers and also how a person would like to be treated in the future (advance planning).

## Recommendations

1. **Policy makers** must consider the reasons why there are rising numbers of people subject to the Act and develop an appropriate policy response.
2. **The Boards of mental health trusts, independent providers of mental health care, and community trusts** are responsible and accountable for the quality of care people receive. They must drive the changes needed in their organisations. In particular they need to recognise and promote good practice and ensure that robust mechanisms are in place to understand individuals' experience of their services. CQC reminds providers of their own duties to monitor how they use powers derived from the Act (see the Code of Practice) and their duties under the Health and Social Care Act 2008 to demonstrate how they have learned lessons from practice and have made consequent improvements. This is an area that CQC will focus on in the next 12 months in its regulatory activity.

3. **The NHS Commissioning Board, local authorities, clinical commissioning groups and specialist commissioners** must commission services that guarantee a person's dignity, recovery and participation. Clinical commissioning groups and local authorities must ensure that local needs assessments for community services and commissioned models of care are informed by an understanding of their statutory duties under the Act and by the experiences of people who use services.

### What CQC will do next

In line with its proposed strategic direction over the next three years, CQC's intention is to strengthen how it meets its responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's unique sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated strong support for this intention and for CQC establishing itself as an effective regulator of the care and treatment of people with mental health problems.

CQC will:

1. Increase the involvement of people who use services in Mental Health Act monitoring work, to inform CQC's understanding of service quality and of risks to the rights of vulnerable individuals.
2. Work with Healthwatch England to develop CQC's understanding of the experiences of people who use health services while subject to the powers of the Act.
3. Focus specifically on the areas of required improvement highlighted in this report. CQC will hold providers to account for positively improving in these areas through the different regulatory approaches at its disposal.
4. Continue to give a focus to good practice in order to promote improvement across the sector.

# Introduction

## How CQC monitors the Mental Health Act

**This is the third annual report by the Care Quality Commission (CQC) on its monitoring of the use of the Mental Health Act 1983 (the Act).**

Mental health is a major issue for the UK. Nearly a quarter (23%) of the total burden of disease is attributable to mental disorder, compared to 16% for cancer and 16% for heart disease. Mental disorder impacts broadly across health, education, work and criminal justice and links to behaviours that put health at risk and premature mortality. Around 300 people out of 1,000 will experience mental health problems every year in Britain. Of these, 102 will be diagnosed by a GP as having a mental health problem, 24 will be referred to a specialist psychiatric service and six will become inpatients in psychiatric hospitals.<sup>1</sup>

Mental health is high on the Government's agenda. In 2011, in its mental health strategy, *No Health without Mental Health*, it stated its commitment to parity of esteem between mental and physical health services. It reaffirmed this commitment in its mandate to the NHS Commissioning Board for the next two years. This legally requires the Board to pursue the objective of putting mental health on a par with physical health. In addition, its consultation on the NHS Constitution proposes amending the first guiding principle on the purpose of the NHS, to explicitly include mental as well as physical health. The Government's mid-term review, published in January 2013, includes improving the treatment

and care of people with mental illness in its four key priorities for health and care.

Every year there are more than 45,000 detentions of men and women in hospital in England for assessment and treatment of mental disorder under the Act. At any time, there are about 16,000 detained patients and a further 4,000 people subject to a community treatment order (CTO).

CQC has a duty under the Act to monitor how services in England exercise their powers and discharge their duties in relation to patients who are detained in hospital under the Act, or subject to CTOs or guardianship. The primary purpose is to provide a safeguard for individual patients whose rights are restricted, and to review the use of legal powers of compulsion. This is the one area of health care where treatment can be expressly imposed on an adult without his or her consent, and it is crucial that there are meaningful safeguards against misuse of the powers of the Act. CQC's monitoring of the Act is one of those safeguards.

The duty is different to CQC's regulatory responsibilities under the Health and Social Care Act 2008, where its focus is on the overall quality of care delivered by the provider. However, CQC uses the evidence that it collects in its MHA monitoring to help it judge whether providers are meeting national standards of quality and safety and take action where necessary to enforce those standards.

In 2009 the UK signed up to the United Nations Optional Protocol to the Convention against Torture (OPCAT).<sup>\*</sup> This requires participating states to prevent torture and other forms of inhuman or degrading treatment through regular visits to places of detention by independent expert bodies called National Preventive Mechanisms (NPMs). The UK designated as its NPM the 18 existing bodies that visit places of detention, covering prisons, immigration centres, children's homes, police stations and psychiatric facilities in England, Scotland, Wales and Northern Ireland.

Because of its role in monitoring places of psychiatric detention in England, CQC has been designated as a part of the UK's NPM. As such its visits help to fulfil the UK's legal obligations under OPCAT.

## Visiting patients subject to the Act

CQC's visits are made by Mental Health Act (MHA) Commissioners. As well as meeting with detained patients and talking to staff, MHA Commissioners carry out specific checks on patient documents, the ward environment, and staffing and patient numbers.

In 2011/12 MHA Commissioners visited 1,546 wards.<sup>\*\*</sup> Of these visits, 811 were unannounced, and 95 took place at weekends. In this way MHA Commissioners can meet with patients and see places of detention without giving detaining authorities notice of their arrival, or see conditions of detention outside normal working hours. During 2011/12 CQC continued its programme of visiting every psychiatric ward in England (where patients are detained) at least once in an 18-month cycle.

<sup>\*</sup> The UN Convention against Torture was ratified in 1984. It aims to establish, as a tool of international law, substantive protection against torture, inhuman, cruel or degrading treatment or punishment. OPCAT, which came into force in 2006, does not establish any substantive rights, but it does establish an international monitoring body of places of detention, known as the UN Sub-Committee for the Prevention of Torture (SPT).

<sup>\*\*</sup> Data taken from CQC's live database on 19 June 2012. Numbers may differ slightly from other published data due to the subsequent completion of records.

Table 1 shows the security level of wards visited over the last two years. More than half of the wards had no specific security designation: these included acute admission wards, most older people's services, and many rehabilitation wards. MHA Commissioners visits included the three high security hospitals, which are visited approximately monthly.

**TABLE 1**

**Security level of wards visited by MHA Commissioners, 2010/11 and 2011/12**

Ward security	2010/11	2011/12
High security hospitals	3%	4%
Medium secure units	13%	14%
Low secure units	23%	20%
No specific security designation	61%	63%

Source: CQC

Note: 2011/12 numbers do not add up to 100% due to rounding

The primary focus of MHA Commissioners' visits to hospitals is to meet in private with detained patients, so that patients can discuss their experiences and concerns. MHA Commissioners also speak with staff about their experiences, plans and concerns, and review legal documents and patients' records. They also check a sample of the statutory forms authorising detention. MHA Commissioners met with 4,569 detained patients in 2011/12, and checked more than 4,500 detention documents.<sup>\*\*\*</sup>

CQC monitors the ethnicity of patients that MHA Commissioners meet. This is to help it meet its equality duties, and in recognition that patients from some minority ethnic groups are overrepresented in the detained population and may be disproportionately disadvantaged in terms of treatment and care. CQC is aware that the reverse may be true for some groups of people: for example, in some areas MHA

<sup>\*\*\*</sup> Data taken from CQC's live database on 19 June 2012. Numbers may differ slightly from other published data due to the subsequent completion of records.

Commissioners had concerns about the low numbers of Asian women accessing services.

Table 2 shows the proportions of people from different groups that met with MHA

Commissioners in 2011/12, compared with the proportions in the general population and in the final 'Count me in' census of inpatients of mental health services, carried out in 2010.

**TABLE 2**

**Ethnicity of patients having private meetings with MHA Commissioners, 2011/12**

Ethnic group	Visits in 2011/12		General population (%) <sup>2</sup>	All inpatients Count me in 2010 (%) <sup>3</sup>
	Number	%		
White British	2,986	65.4	82.8	61.7
White Irish	55	2.0	1.1	0.7
Welsh	4	0.1	0.0	0.0
Other White	190	4.2	3.6	4.4
White and Black Caribbean	55	1.2	0.6	0.5
White and Black African	14	0.3	0.3	0.2
White and Asian	11	0.2	0.6	0.3
Other Mixed	52	1.1	0.5	2.7
Indian	70	1.5	2.8	1.4
Pakistani	48	1.1	1.9	1.4
Bangladeshi	21	0.5	0.7	0.8
Other Asian	70	1.5	0.7	3.6
Black Caribbean	228	5.0	1.2	4.5
Black African	165	3.6	1.5	4.7
Other Black	79	3.4	0.2	5.3
Chinese	20	0.4	0.9	0.4
Other	36	0.8	0.8	1.6
Not stated/not recorded	465	10.2	-	7.6
Total	4,569			

Source: CQC

## Action taken by CQC in response to concerns

The findings of each visit are reported back to the service provider, with requests for action and follow up as necessary. All reports are shared with the CQC compliance inspector for the relevant provider. During their visits MHA Commissioners may also identify concerns or

make observations that are not specifically about the MHA or its Code of Practice – about for example the hospital environment, catering or bed management. MHA Commissioners may raise such matters with providers themselves, or refer them to CQC's compliance managers for further follow-up.

Any concern identified through a check on the operation of the MHA may lead to a CQC review



of compliance under the Health and Social Care Act 2008. Where there has been a breach of the relevant regulations, CQC takes appropriate action under its compliance monitoring framework and enforcement policy.

Appropriate action has been taken in respect of all the specific concerns raised in this report.

## Involving patients

The experiences and views of patients are the principal focus of MHA Commissioners' visits, and are reflected in Commissioners' feedback to the hospitals. The feedback reports highlight good practice that Commissioners have seen, as well as raising any concerns and asking for an action plan to address them. Many extracts from Commissioners' feedback reports are included in this report.

CQC also involves people who use services in all levels of its MHA monitoring work, from policy decisions to visiting. People who are currently, or have been recently, subject to the Act accompany MHA Commissioners on some visits as 'experts by experience'. Members of CQC's Service User Reference Panel (SURP) contribute to discussions about CQC's policies and practices. This report includes a number of SURP members' comments about their experiences.

## Second opinions to safeguard patients' rights

CQC is also responsible for appointing Second Opinion Appointed Doctors (SOADs). SOADs check that, where certain treatments for mental disorder are being proposed without a patient's consent, such treatment is appropriate. This applies to CTO patients who lack the capacity to give consent to treatment and to detained patients who either lack such capacity or, having the capacity to consent or refuse, decide to refuse. In 2011/12, SOADs completed 8,882 visits to detained patients and 3,239 visits to CTO patients.\*

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\* Data taken from CQC's live database in September 2012. Numbers may differ slightly from other published data due to the subsequent completion of records.

## Production of this report

In this report CQC has cross-referenced the findings of MHA Commissioner visits, the concerns of people who use services and professional stakeholders, and policy issues that are relevant to its role in relation to psychiatric detention in England.

To help with this, CQC established an Advisory Group of service user and external stakeholders (see appendix C). It also had consultation meetings with MHA Commissioners and the SURP members.

CQC analysed the quantitative information from the checks on patient documents, the ward environment, staffing and patient numbers.

CQC also carried out some analysis of qualitative findings extracted from the feedback reports written by MHA Commissioners. The most frequently discussed issues were:

- Patient records and care planning
- Ward environment and facilities
- Consent to treatment (including mental capacity assessments)
- Leave of absence from hospital
- Patients' information about their legal position, rights and choices
- Patient privacy, dignity and respect.

These broad areas encompassed many concerns and suggestions raised in the consultation meetings. CQC used the analysis of its MHA Commissioner visit findings and outcomes of its stakeholder consultation to determine the topic areas covered in this year's report.

# 1. Use of the Act

## Key findings

- The number of people subject to detention under the Act is rising. The number of detentions rose by 5% on the previous year; the number of community treatment orders rose by 10%.
- Of the 4,576 patient records checked in 2011/12, 4% showed irregularities that called the legality of the detention into question.
- Care planning was the most frequently raised category of concern; 85% of the care plans examined showed evidence of individualised planning, regular review and evaluation, 15% did not. This was no change on 2010/11 and amounted to just over 650 patients where basic expectations about care planning were not met.
- The greater detail now available in the Mental Health Minimum Data Set has exposed a number of data quality issues that must be addressed before the data can realise its full potential.

## Detentions under the Act

The number of people subject to detention under the Mental Health Act is rising. In total, there were 48,631 detentions in England of men and women in hospital for assessment and/or treatment of mental disorder under the Act in 2011/12.\* A further 4,220 patients were made subject to community treatment orders (CTOs). This was an increase of 5% in detentions and 10% in the use of CTOs, compared with the previous year.

Figure 1 shows all detentions in hospital between 2007/08 and 2011/12. Across the period as a whole, the numbers of patients who were detained after voluntary admission decreased. However, this was more than offset by the increase in patients who were directly admitted to hospital under the Act.

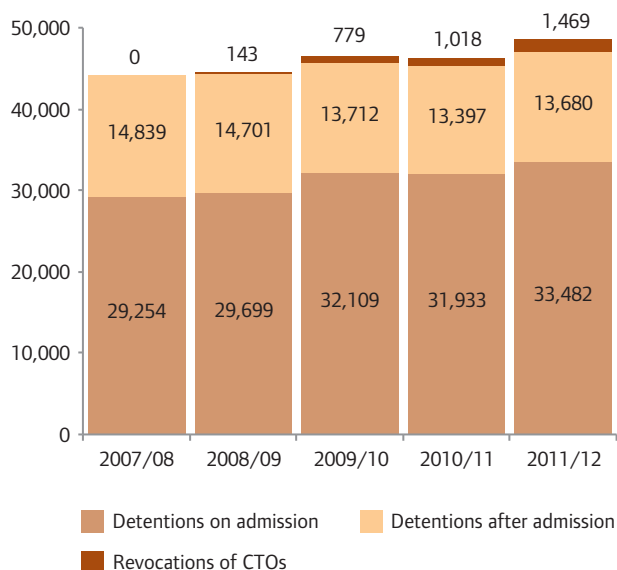
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\* Including revocations from CTO status, see figure 1. CQC defines detentions in hospital to exclude patients who are detained on short-term holding powers (sections 4, 5, 135 or 136) where these do not lead to further detention. This definition is now adopted by the Health and Social Care Information Centre.



**FIGURE 1**

Detentions under the Mental Health Act (admissions and detentions of voluntary patients), 2007/08 to 2011/12



Source: Health and Social Care Information Centre, KP90<sup>4</sup>

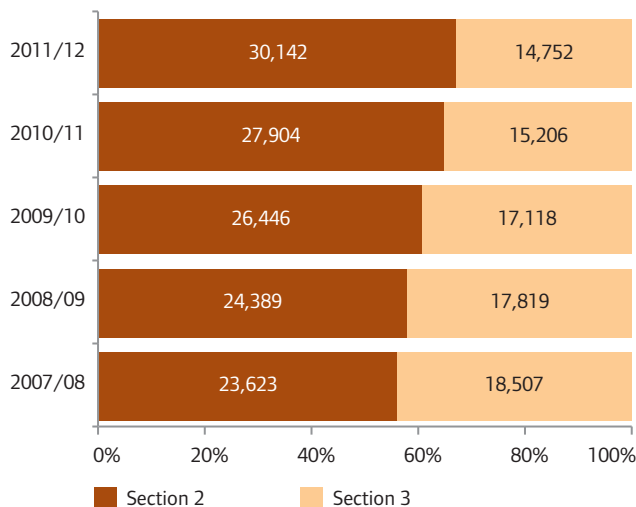
Adding to the increase in the number of detentions are those patients who have had their CTO revoked. In the first full year after the introduction of CTOs in November 2008, revocations of CTOs accounted for 1.7% of detentions; in 2011/12 they accounted for 3% of detentions.

The most frequently used powers of detention under the Act are section 2 (detention for assessment and/or treatment for up to 28 days) and section 3 (detention for treatment for up to six months initially, but then renewable). Although each detention power has slightly different criteria, the Act allows Approved Mental Health Professionals (AMHPs) – those responsible for coordinating assessments and making applications for detention under the Act – some discretion as to which to apply in any given situation.

Figure 2 shows that AMHPs and doctors making decisions to use the Act are increasingly using section 2 to detain patients, and reducing their use of section 3.

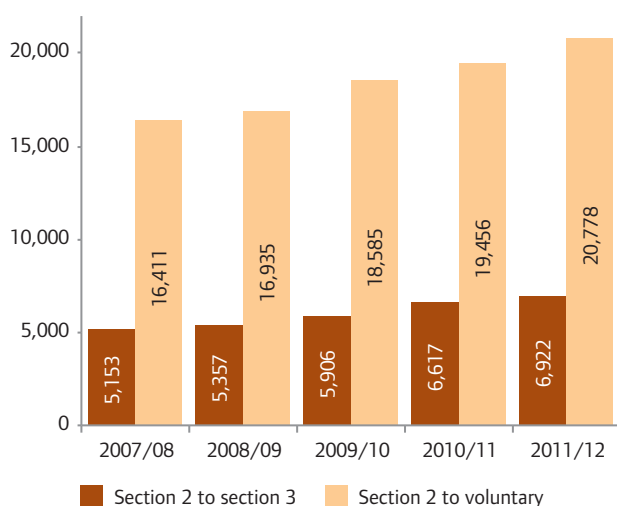
**FIGURE 2**

Use of sections 2 and 3 (admissions and detentions of voluntary patients), 2007/08 to 2011/12



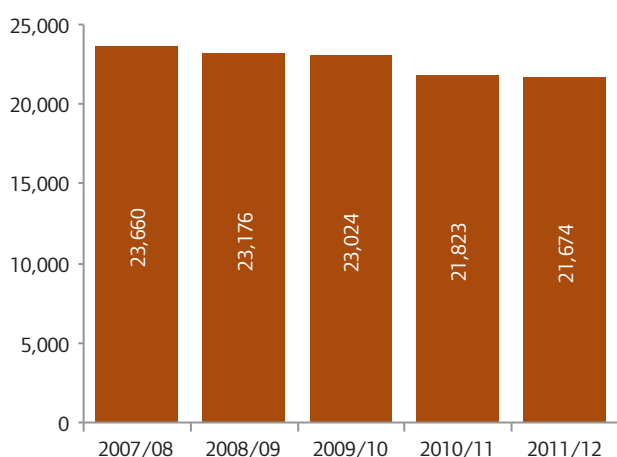
Source: Health and Social Care Information Centre, KP90

If a patient who is detained under section 2 requires inpatient care under detention for longer than 28 days, an application for further detention under section 3 should be made. Figure 3 shows the numbers of section 2 detentions that result in further detention under section 3 and those that result in voluntary inpatient status. The majority of section 2 detentions result in the patient agreeing to remain in hospital as a voluntary patient – this was the outcome of 69% of section 2 detentions in 2011/12, whereas 23% resulted in further detention under section 3. It is likely that the remaining 8% of section 2 detentions resulted in the patient being directly discharged from hospital.

**FIGURE 3****Outcome of section 2 detentions, 2007/08 to 2011/12**

Source: Health and Social Care Information Centre, KP90

Figure 4 shows the total use of section 3 over the last five years, including where section 3 has been used to continue the detention of patients already detained under section 2. It is clear from this that there is a real decline in the use of section 3, even though the overall use of the Act is increasing.

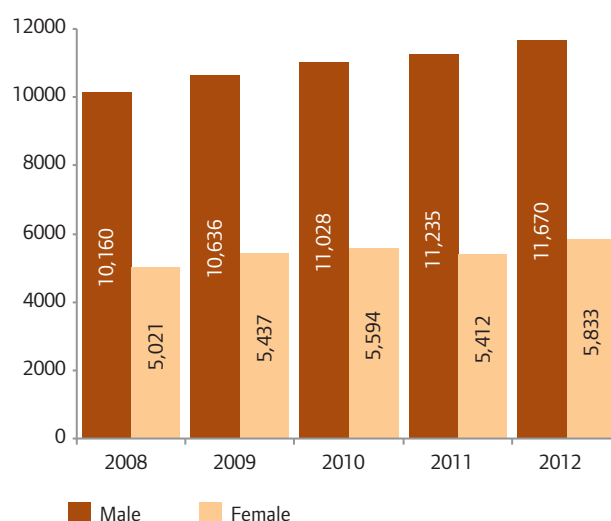
**FIGURE 4****Total use of section 3, 2007/08 to 2011/12 (including detention subsequent to section 2)**

Source: Health and Social Care Information Centre, KP90

There are a number of possible reasons for the increasing use of section 2. It may be that services know less about the patients they are assessing, either because of mental health teams' organisation into 'functional' teams that only deal with parts of patients' care pathways, or because fewer patients are already in hospital on a voluntary basis at the point of assessment for detention. Another factor may be the success of community teams in maintaining people in the community, so they do not deteriorate to the point where they need to be admitted to hospital.

It may also be the continuing influence of the advice given in the *Mental Health Act Manual*. This says that patients whose mental health and circumstances require them to be subject to the very significant procedure of compulsory detention need to be assessed, however well known they might already be to the mental health service.<sup>5</sup> We note below how this trend seems to be increasing the demand on the Tribunal service, although this should improve safeguards for patients.

On 31 March 2012, there were 17,503 patients detained in hospitals in England, an increase of 5% on the previous year (**FIGURE 5**). There are twice as many men as women detained at any one time.

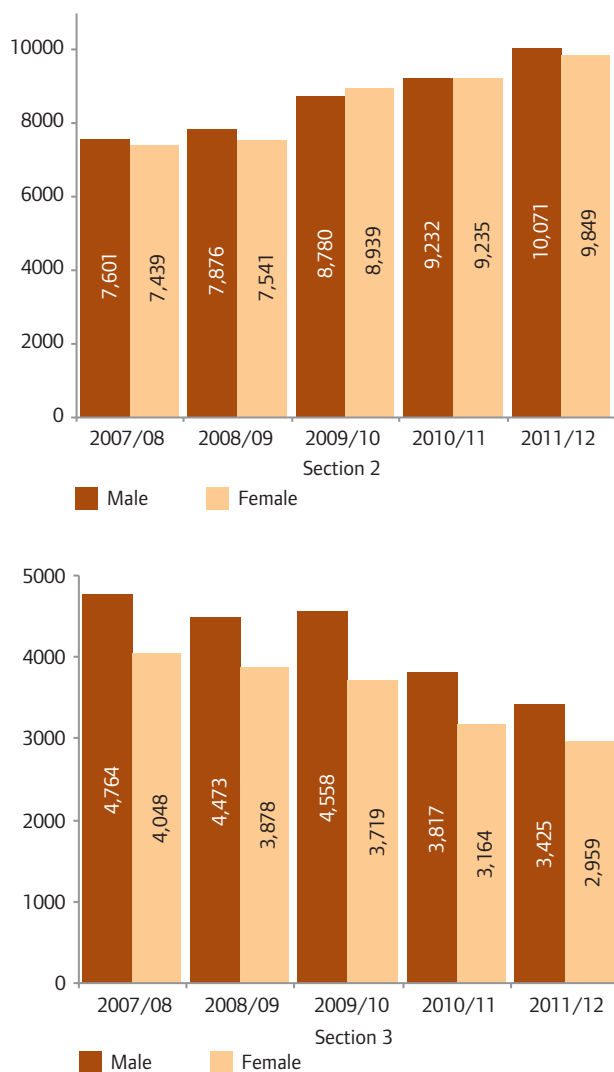
**FIGURE 5****Number of people detained in hospital on 31 March, 2008 to 2012, by gender**

Source: Health and Social Care Information Centre, KP90

The higher number of men appears to be the result of higher rates of admission for men than women under section 3 and 'part 3' powers relating to the criminal justice system (FIGURES 6 AND 7). The part 3 detentions are more likely to last longer.

**FIGURE 6**

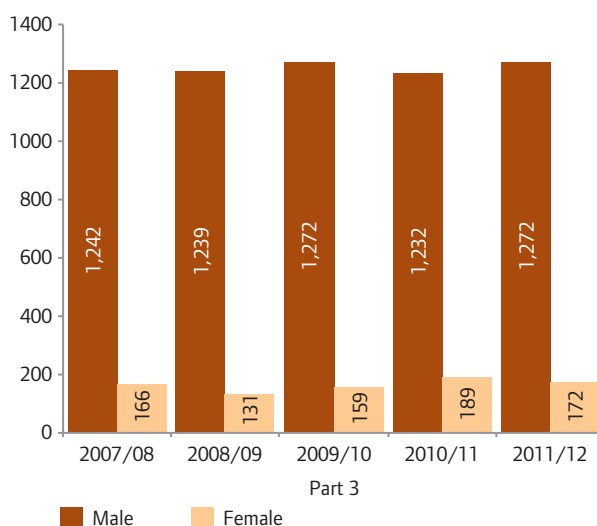
Section 2 and section 3 admissions to NHS facilities, 2007/08 to 2011/12, by gender



Source: Health and Social Care Information Centre, KP90

**FIGURE 7**

Part 3 admissions to NHS facilities, 2007/08 to 2011/12, by gender



Source: Health and Social Care Information Centre, KP90

## Unlawful detention

Of the 4,576 patient records that CQC checked in 2011/12, 4% showed irregularities that called the legality of the detention into question. Although this is a small proportion, it means that more than 180 patients may have been unlawfully detained at the time of CQC's visit.

The following is an example where a MHA Commissioner found problems in the legality of a detention, showing the action that CQC generally requires:

When I reviewed patient 1's notes, I noted that his section papers had been incorrectly filled out at an earlier point of his detention, creating a lengthy period of time in which it mistakenly had been believed he was detained under section. When the problem was realised the unit arranged an immediate assessment and the patient was detained again under section 3. The patient and all appropriate people involved in his care were informed. This however is a very serious error. Please confirm that an audit of all other detentions has been undertaken to ensure that these are all legally correct, and the outcome of this audit.

**October 2011**

## Discharge by the Mental Health Tribunal

The number of applications in 2011/12 to the First-tier Tribunal (Mental Health), and their outcome, is set out at table 3. The Tribunal has reported rising numbers of applications in recent years. A significant proportion of hearings are not held as the patient either withdraws the application or is discharged from detention before the Tribunal takes place.

In 2011/12, 38% of applications did not lead to hearings. Patients were equally likely to be discharged from a section 2 detention as from any other unrestricted section\*: about a third of applications did not reach a Tribunal hearing for this reason.

Patients detained under section 2 were less likely to withdraw their applications (with 8% doing so in 2011/12) than patients subject to other unrestricted detention powers (19%) or restricted detention powers (30%). This is as we would expect, given that there are limited opportunities to apply for a hearing in any period of detention. A tactical withdrawal of an application allows the patient on a longer-term detention power to resubmit it at a later date, with perhaps a better chance of success.

On average, 10% of all detained patients with a Tribunal hearing were discharged by that Tribunal in 2011/12. Within this average there is wide variation between the different types of detention. The Tribunal plays a very significant part in the discharge of restricted patients, ordering some form of discharge for 25% of cases brought before it in 2011/12. It discharged 12% of patients detained under section 2, but only 4% of patients contesting other detention powers were successful.

Not all patients apply to have their detention reviewed by the Tribunal, and many detentions are not long enough to be referred

automatically.\*\* Given this, and the important related equality considerations, CQC is concerned that the gender and ethnicity of applicants are not being monitored. CQC again requests that the Ministry of Justice carries out this monitoring. But it also suggests that hospital services themselves carry out this monitoring at a local level, to ensure that they meet their duties under the Equality Act in providing equal access to justice to all their detained patients.

## Ethnicity and the use of the Act

Data available from the Mental Health Minimum Data Set (MHMDS) for 2011/12, as in previous years, shows a continuing trend in high rates of detention amongst certain black and minority ethnic groups. Appendix A contains details of an analysis of this data showing the standardised rates of admission and detention for 2011/12.

Key findings from this analysis are:

- Hospitalisation rates as voluntary patients were lower than average for patients from the White British, White /Asian Mixed, Indian, Pakistani, Bangladeshi and Chinese groups.
- Hospitalisation rates as voluntary patients were higher than average for patients from the White Irish, Other White, Other Mixed, Other Asian, Black Caribbean, Black African, Other Black and Other groups.
- Detention rates were also lower than average for patients from the White British, White/Asian mixed, Indian and Chinese groups.
- Detention rates were higher than average for patients from the Other White, White/Black Caribbean Mixed, White/Black African Mixed, Other Mixed, Other Asian, Black Caribbean, Black African, Other Black and Other groups.

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\* All patients detained in hospital for treatment, including patients subject to the civil powers of section 3, as well as detention powers under part 3 of the Act including sections 37 and 47, where these are not subject to 'restriction orders' under sections 39 or 49, relating to oversight by the Secretary of State for Justice.

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\*\* Hospital managers have a duty to refer patients to the Tribunal after six months of continuous detention (or detention followed by CTO status), where an application has not been made against section 3 detention or CTO within that period (MHA 1983, s.68). Managers also have a duty to refer any detained patient who has not appealed to the Tribunal for a period exceeding three years, or one year if the patient is under 18 years of age (MHA s.68(6)).

**TABLE 3****Outcomes of applications against detention to the First-tier Tribunal (Mental Health), 2011/12**

		<b>Section 2</b>	<b>Other unrestricted</b>	<b>Restricted</b>	<b>All detained patients</b>
	Applications	7,768	14,674	3,262	25,704
	Withdrawn applications	617	2,821	993	4,431
	Discharges by clinician prior to hearing	2,562	4,914	83	7,559
	Hearings*	5,145	8,391	2,512	16,048
Decision of Tribunal	No decision (i.e. adjournment)	997	2,502	461	3,960
	Absolute discharge	434	233	106	773
	Delayed discharge	169	134	0	303
	Conditional discharge	0	0	306	306
	Deferred conditional discharge	0	1	207	208
	Total discharge by Tribunal	603	368	619	1,590
	No discharge	3,545	5,521	1,432	10,498

Source: Tribunal secretariat

\* The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.

- Detention rates were particularly high for Other Asian, Black Caribbean, Black African, Other Black and Other groups with rates 2-13 times greater than expected.

Ethnicity in relation to community treatment orders is discussed in chapter 6.

It is notable that the Health and Social Care Information Centre's Mental Health Bulletin analysis for 2009/10 and 2010/11 shows the broad ethnic Mixed, Black and Other groups having much higher rates of access to the full range of secondary mental health services, including those provided outside hospital, than the White and Asian groups.<sup>6</sup>

A study commissioned by the Department of Health may offer further insights into the reasons for the continuing high detention rates amongst certain ethnic groups. The AMEND study, led by Professor Swaran Singh at the University of Warwick, explores whether the amendments to the Act in 2007 have led to any change in

the numbers, proportion, diagnostic status and ethnic background of people being detained by mental health services. It compares the characteristics of patients assessed under the Act over a four-month period (July to October) over four successive years, from 2008 to 2011.

Data has been collected in three mental health trusts: Birmingham and Solihull Mental Health Trust, West London Mental Health Trust and Oxfordshire and Buckinghamshire Mental Health Foundation Trust. The service level, socio-economic and ethnic mix of the catchment population across these sites (total population 4.2 million) will ensure that the findings of the project are generalisable to a national level. The findings will be available by spring 2013.

## MHMDS data quality

Changes in 2011/12 to the way that the MHMDS is submitted and processed (MHMDS version 4) provide a much richer data source for analysis of the Mental Health Act – one that could describe the sequence of uses of the Act for individual patients and the outcomes for patients of being made subject to the Act, as well as providing a wide range of demographic and organisation level breakdowns.

However, the greater detail now available in the data has exposed a number of data quality issues that must be addressed before the data can realise its full potential. At present, the range of analysis which the data can reliably support is being explored and the Health and Social Care Information Centre (IC) is taking a number of steps to assist providers in tackling issues with their submissions. The main issues and actions for improvement are:

- **Coverage:** Experimental analysis included in this year's national statistics on uses of the Act showed what additional value (for example, breakdowns by ethnic group) can be provided.<sup>7</sup> However, comparative figures from the KP90 collection and from the MHMDS show that some providers are still not including comprehensive information in their MHMDS submissions.
- **Accuracy:** Many provider submissions include incomplete or duplicated information, which makes the analysis of uses of and transitions between different sections difficult – for example, submissions that say a patient was subject to more than one section of the Act at the same time or that do not show the date when a section ended. The IC has issued additional guidance to providers to clarify the submission requirements and to emphasise the importance of providing information about when detentions ended.<sup>8</sup> They are also introducing new diagnostic reports into the submission process in 2012/13. The IC will work with stakeholders to see if any additional guidance on submissions would be helpful.
- **Consistency:** MHMDS submissions are currently made every quarter (and from April 2013 will be made monthly, to support the implementation of Payment by Results for mental health). Inconsistencies or gaps in the MHA information included in these routine submissions make it impossible to build a coherent picture of an individual patient pathway, which may last for months or years. The IC already produces analysis of 'detentions on admissions to hospital' in its routine quarterly publication, which providers should use to check against locally held information.<sup>9</sup> However, the IC now plans to introduce further basic checking measures into their quarterly publications to highlight these issues, so that providers can identify areas where there may be issues in their data extraction or submission routines.

Unless this issue is addressed, it will be hard to create the coherent whole year picture of patient care from the routine submissions that is required to support analysis of the duration and outcomes of care.

The IC is applying to the Review of Central Returns to continue the KP90 collection at least for 2012/13. However, the KP90 data collection has been highlighted as one that may be discontinued at some point in the future, so improving data quality is critical.

Providers that record their use of the Act in the MHMDS should review the way in which data about the Act is extracted from local systems and ensure that it is being entered correctly in routine MHMDS submissions. It is suggested that all relevant staff (for example, Mental Health Act Administrators as well as information staff) make use of all the information provided by the IC at different points in the submission process to check the accuracy of their data.



## 2. Participation and respect

### Key findings

- CQC's MHA Commissioners visited many mental health wards where a great deal of respect was given to patients.
- Patients were able to influence the running of their ward in almost all cases – 94% of all wards in 2011/12, up from 90%.
- Patients were more involved in planning their own care: their views were recorded in 63% of care plans, a rise from 58%. But this means an unacceptably high proportion – more than a third – did not have their views written down.
- More than half of patients were still not given a copy of their care plan.
- Most patients (90%) were given general information about their rights when they were first detained.
- But one patient in five was not informed of their right to an Independent Mental Health Advocate (IMHA).
- This may reflect continuing difficulties that some services have in accessing IMHAs. There was no evidence of an IMHA service in one in seven of the wards CQC visited.

The guiding principles of the Mental Health Act Code of Practice require that when health and social care professionals take decisions to exercise their powers, they should recognise and respect the diverse needs, values and circumstances of each patient. The Code also requires that patients must be given a say, as far as is practicable, in planning, developing and reviewing their own treatment.<sup>10</sup> The importance of patient involvement to the outcome of medical interventions is recognised by NICE.<sup>11</sup> The implementation framework of the Government's mental health strategy *No Health Without Mental Health* enshrines the principle of 'no decision about me without me' and promotes patient involvement at an individual and collective level.<sup>12</sup> It is important to ensure that patients subject to the Mental Health Act are included in the implementation measures that this sets out.

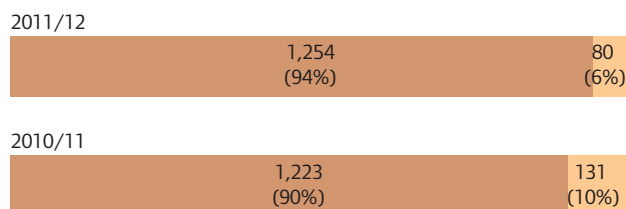
CQC pays particular attention to these requirements when monitoring the care and treatment of patients subject to the Act.

CQC saw examples of good practice in patient involvement on its visits. Between 2010/11 and 2011/12, the proportion of wards that CQC visited that had mechanisms for patients to engage as a group in influencing the running of the ward, such as community meetings or patient councils, rose from 90% to 94% (**FIGURE 8**). This reflects much progress made in recent years in giving detained patients a voice in the running of services, and respect both for their experiences and as individuals.

**FIGURE 8**

### Patients' involvement in running the ward, 2010/11 and 2011/12

Does the ward provide detained patients with an opportunity to influence the running of that ward through ward community meetings, patient councils or similar arrangements?



Source: CQC

There were also good examples of wards where patients were fully involved individually in planning their own care and treatment, and provided with the tools to make such involvement meaningful. Following a visit to a psychiatric intensive care unit, a MHA Commissioner wrote this visit summary for the detained patients on the unit:

Any issues raised by individual patients were discussed with staff on the day of [our] visit as agreed with each patient. On the whole [we] heard that you are very happy with the care you receive on the unit. You told [us] that staff listen to you, treat you with respect, explain your treatment in full and seek your opinions and views about your care at all times.

**April 2011, Miranda House, Humber Mental Health NHS Foundation Trust**

### Care planning

In the analysis of the issues raised on MHA Commissioners' visits in 2011/12, care planning was the most frequently raised category of concern. In CQC's visits to detained patients and patients subject to community treatment orders (CTOs), 85% of the care plans examined showed evidence of individualised planning, regular review and evaluation (**FIGURE 9**).

### A positive care planning experience

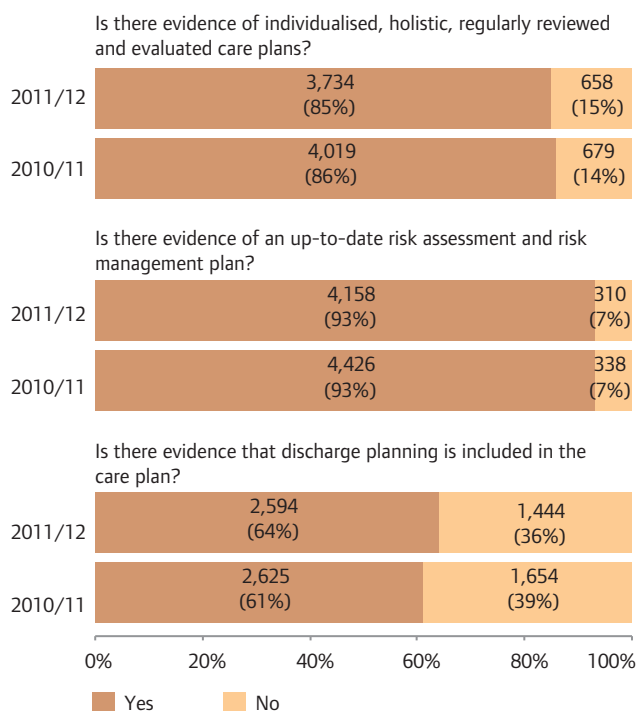
BB During my section in 2011 my granddad was ill with cancer, we knew he didn't have a lot of time left so I approached staff and asked if we could put a care plan in place for when he did pass away. I did this because I wanted to have my own views of how I wanted to be managed when the bad news came. My views and wishes were taken into account and together with my named nurse and social worker I made my own care plan of how I wanted to be managed and what support and care I thought would be necessary. A copy of the care plan was sent to all nurses on my ward so they could see it. Unfortunately, the time did come and I was given the sad news that he had passed away but as my views and wishes had been taken into account I felt the whole situation was handled well and I was given the care and support I needed and had asked for.

DD

### Service user detained under section 3

While this means that the majority of the care plans sampled met or exceeded CQC's basic expectations of individualisation and holistic care planning, it also means that there was no evidence of this in 15% of the care plans CQC looked at. This amounts to just over 650 patients, and is no improvement on the percentage of care plans in 2010/11 that did not meet basic expectations. When MHA Commissioners see this issue on their visits, they raise it in their feedback to the detaining authority, ask for corrective action, and continue to monitor carefully.



**FIGURE 9****Analysis of care plans, 2010/11 and 2011/12**

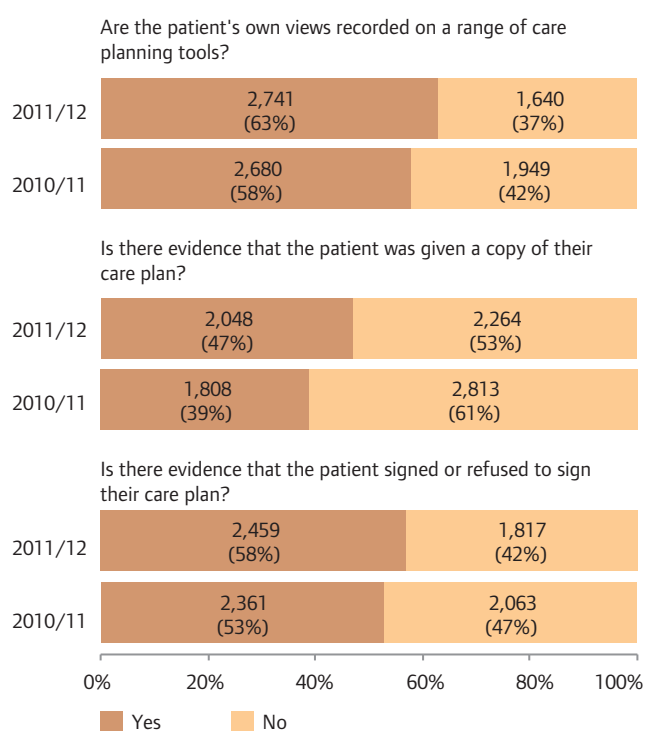
Source: CQC

In line with national guidance on the Care Programme Approach, hospitals should keep an up-to-date risk assessment and risk management plan for patients subject to the Act, to both inform treatment and justify the continued use of legal compulsion.<sup>13</sup> CQC found no evidence of this in more than 300 of the care plans examined in each of the last two years (**FIGURE 9**). This is a serious failing in responsible authorities' duties. Risk assessment is an essential and ongoing element of good mental health practice and a critical and integral component of all assessment, planning and review processes.

The poorest area of performance in this area was demonstrating discharge planning in patients'

care plans. Only 64% of care plans in 2011/12 included discharge planning, although this did represent a small improvement from 2010/11. The Code of Practice requires that hospitals start to plan aftercare as soon as a patient is admitted to hospital<sup>14</sup>, and as such all care plans should have some reference to discharge planning. This is discussed further in chapter 4 below.

Patient involvement in care planning has increased since last year but it remains relatively low (**FIGURE 10**).

**FIGURE 10****Patients' involvement in care planning, 2010/11 and 2011/12**

Source: CQC

“ I don't know much about care plans. I don't have much experience of them ”

Service user detained under section 3 (age 26, detained periodically from age 17)

Despite an increase of 8% from the previous year, in 2011/12 more than half of the records reviewed did not indicate that the patient was given a copy of their own care plan. Some care plans did not articulate patients' needs sufficiently, so that these could be taken account of in their ongoing care:

I was concerned that in some places care did not appear to be person-centred. I scrutinised one set of care documents where the care issues were identified only as: "actively psychotic", "NFA" and "psychosis"... [in] another example a patient had needs identified as "does not comply with CTO conditions", "promote recovery" and "section 3".

#### **February 2012**

In some cases staff had clearly recognised the expectation on them to draw up care plans collaboratively and ensure that patients' views were included. However, they seemed to be unable to adopt such a culture in practice. In the following example, the use of language suggests that the entries were not an accurate representation of patient views:

Most care plans did not reflect patient views. However, plans had been completed in the first person in some areas, e.g. "I want to be empowered to concord with my medication" and "for me to understand her rights". This appeared to reflect the nursing staff views rather than first hand reflections from patients.

#### **September 2011**

In the visit from which the above example was taken, several patients said that they felt that they had no choice but to sign their care plan, even if they did not agree with it. Such signatures cannot be taken as reliable evidence of a patient's consent to a care plan. Patients may also think that by signing a document they are signing some form of legal contract. Services that ask patients to sign their plans should be particularly careful to explain that this in no way alters the position that the patient may withdraw their consent at any time. The impression of a legal contract can be avoided by having a space where the patient can

record their comments, including any reservations they might have about the plan.

On a CTO visit in February 2012, there was limited evidence of patients' views in their clinical notes – even though these contained otherwise complete recovery, intervention and wellbeing plans, and included a section called "what I would like to happen". The Code of Practice expects care plans for CTO patients to be closely tailored to the personal needs of the patient so as to re-establish their lives in the community with support and monitoring. CQC has noted in previous reports that there appears to be some correlation between the level of such personalisation and the degree to which patients view their treatment under a CTO in a positive light.<sup>15</sup>

In a small minority of cases, patients were not involved in the development or review of their care plans and had little engagement with them, even though they evidently had capacity for such engagement:

None of the patients interviewed knew what was in their care plan. None felt involved in planning their care, or in any decisions made about their treatment. None knew what the plans for discharge were, or what they had to do to prove that they were ready for discharge. This is contributing to a general sense of frustration expressed by all the detained patients interviewed... born from a lack of sense of involvement. This ranged from patient 1 not knowing that he was detained to patients 2 and 3 both wondering what it was that they had 'done wrong' to warrant being locked in hospital.

#### **October 2011**

Where MHA Commissioners see good practice, they often hear from patients of the important difference this makes to their feelings about their care and treatment:

“ I have a very detailed care plan that was done by my community psychiatric nurse from the last time I was unwell. I believe that my wishes will be hopefully respected due to the lengths it has been talked about by my social worker and psychiatrist ”

Service user detained under section 3

“ I feel that professionals involved in my care listen to what I say about my medication and the best way forward when it comes to my treatment in general. This is because I have prepared an advance statement and hopefully they will follow my wishes ”

Service user detained under section 3

## Advance statements of wishes and feelings

Care planning should provide an opportunity to incorporate patients' wishes about treatment into advance statements of treatment preference, or advance directives of treatment refusal. The Code of Practice suggests that encouraging patients to set out their wishes in advance will often be a helpful therapeutic tool, promoting collaboration and trust between patients and professionals.<sup>16</sup> This is supported by NICE guidance.<sup>17</sup>

Although there is only limited research evidence, one study has shown a reduction in assessments and involuntary hospitalisation under the Act where patients had drawn up an advance statement in collaboration with their psychiatrist, their care co-ordinator and a project worker.<sup>18</sup> Advance statements that patients draw up with the support and collaboration of healthcare professionals could therefore be an alternative

to the use of CTOs. CQC suggests that clinicians who are thinking of a CTO for their patients should consider whether that patient has had an opportunity to make an advance statement of wishes, and Approved Mental Health Professionals may wish to consider whether such an opportunity might be an addition or alternative to a CTO.

There are publicly available resources that may help services develop their own practice in relation to advance directives. Nottinghamshire Healthcare NHS Trust has produced a useful template of an advance directive for mental health service users, including easy read versions, and made these publicly available.<sup>19</sup> Mersey Care NHS Trust has reported on its proactive advance directive project, which linked advance directives to electronic patient records to ensure that they were available to any health professional.<sup>20</sup>

Hospital managers should ensure that detained patients are given the opportunity, with the

collaboration and support of their treating team, to draw up advance statements of treatment and care preferences.

## Providing patients with information

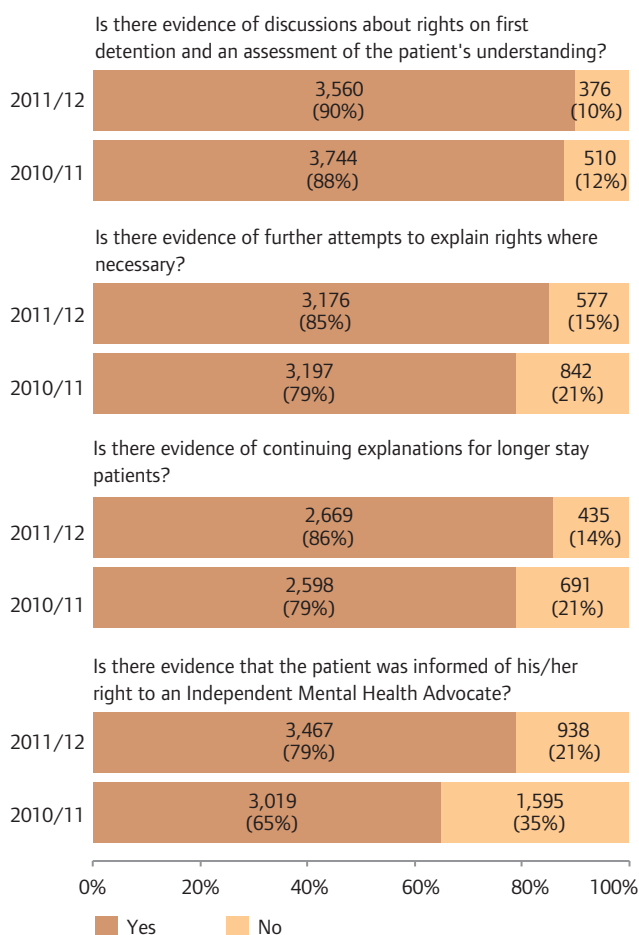
The Act places a duty on hospital managers to take practicable steps to ensure that patients understand their rights, and to do so as soon as practicable after a patient's detention begins.<sup>21</sup> The Code of Practice expects this to be repeated at intervals and managers to have a policy on how this is to be done.<sup>22</sup>

Scrutiny of individual patient records showed that in 90% of cases, patients had been given information about their rights when first detained. This shows some improvement in services' records of meeting this duty (**FIGURE 11**). However, MHA Commissioners reported a lack of evidence of staff discussions with patients about their rights on 458 visits overall. In some cases discussions had taken place but they were not recorded; in others patients were unaware of or unclear about their rights. In a number of cases the relevant forms (section 132) were missing or incomplete.

The poorest performance was in providing patients with specific information of their right to request help from an Independent Mental Health Advocate (IMHA). There was no evidence that patients had been informed of their legal right to an IMHA in 21% of records reviewed in 2011/12. While this is an improvement on the 35% of records examined in 2010/11, the relatively high level of failure may be a reflection of continuing difficulties that some services have in accessing adequate IMHA provision (see below).

**FIGURE 11**

### Provision of information to patients, 2010/11 and 2011/12



Source: CQC

While hospital staff have a legal duty to ensure that patients are aware that they can ask to see an IMHA<sup>23</sup>, MHA Commissioners talked to patients who either did not know that they could do this, or did not understand how the IMHA service might help them:

Whilst the ward had notices about the IMHA service, it is not clear that the duty on the hospital to ensure that qualifying patients were routinely and individually informed of the availability of the IMHA service was being met. In particular for this patient group, there also needs to be consideration of making a referral to the IMHA service where the patient is unlikely to refer him or herself but may benefit from the IMHA service.

July 2011

In the above example CQC asked for systems to be established to ensure that patients were routinely informed verbally and in writing of the IMHA service, and that staff referred incapacitated patients to the IMHA service where appropriate. Where CQC has made such recommendations, it has often seen evidence of changes in practice and notes that overall compliance with the legal duties regarding IMHA improved between 2010/11 and 2011/12. Within three months of providing the feedback in the example immediately above, MHA Commissioners revisited the hospital and were able to report that:

**Ward staff have a good understanding of the role and function of the IMHA service and are discussing this appropriately with patients. This is highlighted as a matter of good practice.**

**September 2011**

MHA Commissioners spoke with some staff who reported feeling duty-bound to periodically 'read the rights' to patients, even though they thought this was distressing to the patient and of no real value. CQC has been asked for an opinion on whether there is a maximum or minimum number of attempts that must be made to get a patient to understand his or her legal position.

The law allows for an approach measured to the needs of each individual patient. CQC suggests that the word "practicable" in relation to the giving of information\* must be read in the light of case law from 2005 relating to the duties to consult with nearest relatives, also qualified with the phrase "if practicable".<sup>24</sup> In 2005 the court ruled (against the interpretation of the Code of Practice at that time) that practitioners were entitled to weigh any detrimental impact on a patient in considering whether it was 'practicable' to discuss their case with their nearest relative.\*\* As such, although it is of

course of great importance that patients have an opportunity to understand their rights (including rights to advocacy or to appeal the use of compulsory powers), if continued attempts to explain these has a detrimental impact that is disproportionate to any advantage gained, then attempts should be suspended until any change in the patient's circumstances.

The Code suggests that it will usually be appropriate for professionals working with the patient to provide the information about rights required by statute. In some instances, CQC is concerned to see this role delegated to IMHAs. Although IMHAs also have a statutory role to give patients information about their legal status, their rights and how to exercise them, this duty is described in the Code of Practice as an "additional safeguard".<sup>25</sup> It does not relieve nursing staff or other professionals who work under the direction of the hospital management of their duties under section 132.

In practical terms, nursing staff have much greater contact with detained patients than IMHAs, and are best placed to ensure that patients get the best opportunity to understand and exercise their rights. Furthermore, nursing staff should be engaging with patients, supporting them in regaining their autonomy, and being clear and open about the legal position and the choices open to them (for example in relation to consent to treatment). Although the Code is not explicit about this, CQC's view is that 'delegating' the function of information delivery solely to IMHAs is not a robust approach to discharging this critically important role of hospital managers. CQC would expect nursing staff in particular to continue to record their discussions with patients regarding legal status and rights.

Service provider boards should assure themselves that clinical teams take responsibility for providing patients with information, and co-ordinating patient involvement in service delivery. IMHAs should not be used as a substitute for hospital or community staff in either of these important areas.

CQC expects that provider boards will have ways of checking whether their legal duties are being

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\* Section 132(1) of the Mental Health Act 1983 states that the managers should take "such steps as are practicable" to inform patients of specific legal information and rights, "as soon as practicable" after the start of detention.

\*\* The revised *Mental Health Act Code of Practice* (2008) reflects the court's judgment at para 2.32.



met by staff. In 2009 and 2011 South West London and St George's Mental Health NHS Trust audited its patients' understanding of their legal rights using a pro-forma on a number of wards. The results showed a marked improvement in the levels of understanding among both detained and voluntary patients from the first audit to the second, although there was still room for improvement. A paper published about the exercise highlights the need to improve staff awareness of responsibilities in providing rights information to patients, and suggests that local presentation of audits can improve practice in this respect.<sup>26</sup> This needs to be addressed, with particular attention to responsibilities for providing information about rights to patients on community treatment orders.

## Information for relatives and carers

In CQC's meeting with a group of carers of people detained for the first time, they said that they did not always feel that they received adequate information about what was happening around them. They said that police officers, AMHPs and clinical staff sometimes assume that carers have a level of knowledge about the Act and local services that they do not have. For example, one carer was informed by the police that their relative was detained at a particular unit, but the carer did not know what or where that unit was and found it difficult to find this information.

A useful factsheet for nearest relatives has been produced by Rethink Mental Illness, with support from the Approved Mental Health Professional Community of Interest at the College of Social Work. The factsheet explains the definition, role and rights of the nearest relative under the Act.

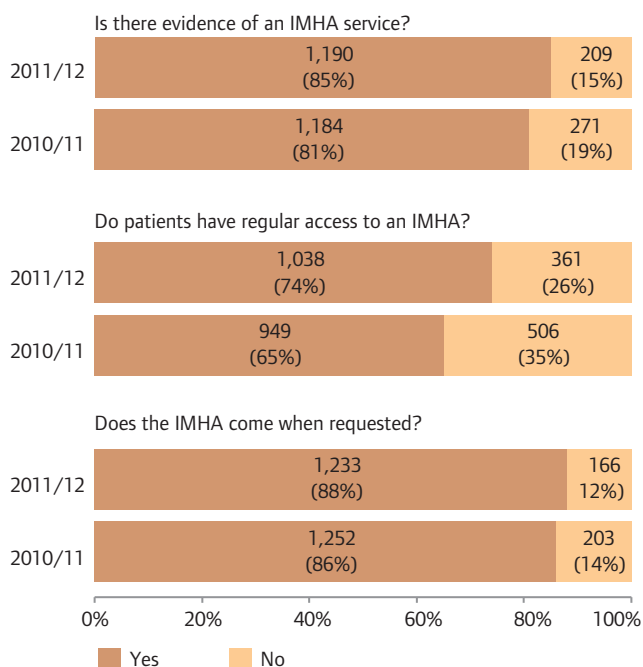
## Availability of independent mental health advocacy

Since April 2009, primary care trusts have been under a legal duty to provide IMHAs to qualifying detained patients, and patients subject to a CTO or guardianship.\* In 2011/12, CQC found evidence of an available IMHA service in 85% of the wards it visited (**FIGURE 12**). While this is an improvement on the 81% of wards with IMHA provision in 2010/11, it still represents a significant number of PCTs that are failing this particular legal duty.

Regular access to IMHAs is a problem in over a quarter (26%) of wards visited by MHA Commissioners. This is an improvement from the previous year, when CQC found that 35% of wards could not provide regular access to IMHAs.

**FIGURE 12**

### IMHA provision, 2010/11 and 2011/12



Source: CQC

\* Mental Health Act 1983, s.130A. Detained patients who do not qualify for IMHA services are those subject to ss.4, 5, 135, or 136. Detained patients on leave of absence from hospital qualify, as do voluntary patients who are either being considered for neurosurgery for mental disorder or (being aged under 18) ECT.

Research into IMHA, commissioned from the University of Central Lancashire by the Department of Health and published in June 2012<sup>27</sup>, identified considerable variation in the access to and the quality of IMHA services, and confirmed the findings from CQC's visits of particular difficulty in out-of-area commissioning arrangements.<sup>28</sup> The research suggested that IMHA services had not yet reached their full potential and that measures could be taken to improve access.<sup>29</sup>

The authors of the report suggested that access could be improved by qualifying patients having to opt out from, rather than opt in to, advocacy support, and that such a scheme should be considered in consultation with service user groups. In the meantime, commissioners of IMHA services could ensure that they enable advocates to spend time on the wards they cover to proactively engage with patients.

Commissioning of IMHA services moves to local authorities in April 2013, although responsibility for promoting access will remain with providers. Local authorities will be taking on this commissioning role at a time of financial austerity, and CQC hopes that the recommendation of the research is heeded:

"The transfer of commissioning responsibility from PCTs to the local authorities could ... be problematic for IMHA service development, particularly if adequate resources are not ring fenced for this purpose... in addition, the importance of the mental health services context in determining the quality of IMHA provision needs to be recognised and, thus, local authority commissioners will need to work in partnership with health service commissioners to provide the necessary conditions for the successful operation of IMHA services."<sup>30</sup>

CQC expects to see local authorities working in partnership with clinical commissioning groups to ensure that the right of access to these services for detained patients is adequately addressed in local needs assessments.

## IMHA and CTO patients

On a number of visits to CTO patients, MHA Commissioners found that patients were generally unaware of the existence or availability of IMHAs in the community. When they discussed this with CTO patients, many showed an interest and requested that they be referred to the IMHA. In one London trust, there was a 'community IMHA' separate from the advocacy provided to inpatients, but when the MHA Commissioner spoke to that IMHA she reported minimal referrals for CTO patients. The Commissioner found that the Mental Health Act Administrator at the trust was unclear about how to refer patients to the community IMHA, and patients appeared unaware of their right to an IMHA.

On two other visits, patients told MHA Commissioners that they were aware of the IMHA service as inpatients, but did not know that it extended to them once they were discharged onto a CTO. In both cases the local IMHA services reported that they had done little or no work with CTO patients, although from discussions with such patients it was clear that there was a need and a potential demand for such work.

IMHA services and trust managers should work together to consider how access to IMHA can be better signposted for those under CTO. They should consider the role of staff in making direct referrals to the service, as permitted under the Act, and ensure that staff are systematically informing patients of the existence of IMHA services. CTO policies should highlight:

- The right of staff to make direct referrals to the IMHA service.
- Code of Practice guidance on the need for positive encouragement of patients to access advocacy.
- The need to periodically revisit the issue of patient rights in contact with patients.<sup>31</sup>

## Respect

MHA Commissioners see a great deal of respectful and compassionate professional practice, as in the following example from a ward for older people with cognitive impairment:

Three patients were seen on the day, two whilst having lunch, and the third with her carers. They were all very confused. However, staff were observed to deal with patients' confusion and agitation in a caring, calm and compassionate way, and the staff team are to be congratulated on their approach. The carers of patient 2 were also very positive about the care that their wife/mother was receiving and they were very pleased that she had settled well on the ward.

**February 2012, Altham Meadows, Lancashire Care Foundation Trust**

The national Star Wards initiative has shown that there are many excellent practices aiming to make patients feel valued and better about themselves. Many of these stem from small but important acts that show warmth and humanity. Such acts, reported in the Star Wards literature, include staff eating alongside patients; giving out bags of toiletries on admission; and arranging for library services to be available to patients.<sup>32</sup> A key focus of Star Wards is the interaction between staff and patients, describing "the single most important element of inpatient care" as "equitable, trusting, healthy relationships between patients and staff and among patients ourselves".

On 81 of CQC's visits, patients raised concerns about their interaction with staff. These included complaints of staff rudeness or disengagement; patients being made to feel inferior or not taken seriously by staff; and allegations of name calling and bullying. In a minority of these, allegations were made of physical abuse of patients by staff. CQC recognises that there may often be tensions between patients undergoing compulsory hospital treatment and the staff employed to care for them, but it takes patients' concerns seriously and always follow them up on visits:

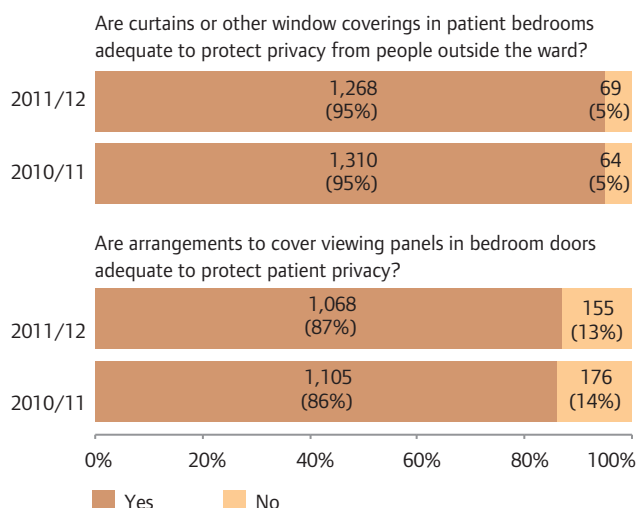
Some patients talked about the atmosphere on the ward as being one characterised by mistrust rather than being one of partnership and respect between staff and patients. This appeared to relate to particular staff members on the ward whom the patients found to be abrupt and rude and this seemed, for some patients, to set the overall tone and culture of the ward. Patients said, for example, that some staff routinely did not knock before entering bedrooms, and how some staff are often very busy and not approachable.

**November 2011**

In a few examples MHA Commissioners saw facilities being used in ways that compromised patient dignity. On a visit studying seclusion practices in a high security hospital in December 2011, there were different practices in how food was delivered to patients in seclusion. In one ward food would always be passed to the patient through the door hatch, which was concerning as it may not always have been necessary to take this precaution. On another ward, there was a commitment to enter the seclusion room to deliver food, even if this required the patient to be asked to sit on the bed and the food left just inside the room. Limited staff resources or the attitude of individual staff seemed to interfere with this commitment, as we had observed and been told by patients that food was sometimes delivered through the hatch, even though on this ward the hatch was positioned so that the food was delivered through to the seclusion room toilet. This cannot be acceptable practice.

Ward environments play an important role in enabling staff to maintain patients' privacy and respect. However, even where patients had their own rooms, there were times where this did not guarantee sufficient privacy. For example, in 13% of wards visited in 2011/12, the arrangements to cover viewing panels in bedroom doors were not adequate in protecting patients' privacy **(FIGURE 13)**.



**FIGURE 13****Privacy arrangements, 2010/11 and 2011/12**

Source: CQC

On a dementia unit in October 2011, a MHA Commissioner saw shared bedrooms with inadequately covered windows, on a ward where some male patients had to walk through the female area of the ward to reach their own bedrooms. The hospital managers installed film coverings to the windows to provide privacy until more permanent arrangements could be made. MHA Commissioners also found wards where bedrooms with external windows were inadequately curtained or screened, as in the following example from an adolescent unit:

A patient on the acute corridor informed that the bedroom does not have any curtains and, though windows are tinted, people from outside have waved.... Staff provided reasons of risks and ligature points.

October 2011

The hospital managers responded to CQC's concern by installing curtains on an anti-ligature rail in the patient's room.

A more common problem was the covering of observation windows or spyholes in bedroom doors. In many cases, these observation windows have internal blinds that can be operated by staff from the corridor. Ideally these should have an internal control so that patients can close the blind if it is inadvertently left open.

On some wards MHA Commissioners found that staff were not giving sufficient regard to patients' need for privacy.

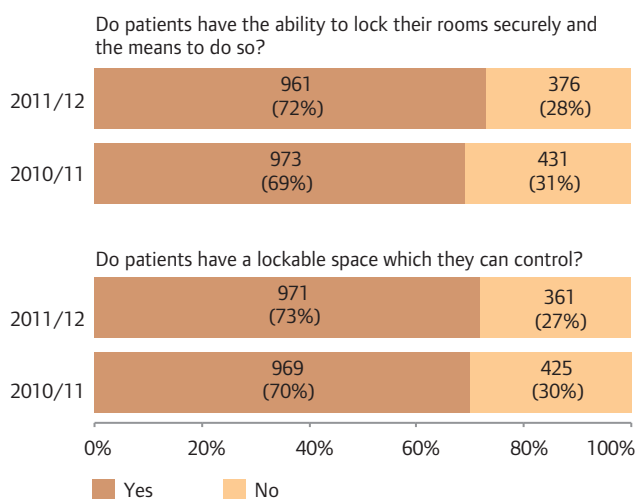
I heard from one young person that some staff enter her bedroom or bathroom without knocking or without waiting for a response from the young person, causing her to frequently choose to get undressed/dressed under the quilt or inside her wardrobe.

December 2011

In the above case, the requirement for staff to knock and wait for a response before entering patients' rooms was raised in nurse business meetings following the visit.

Where patients are deprived of their liberty by compulsory hospital admission, issues of residual privacy and control over their personal environment become even more important. The ability to lock a bedroom and/or control a lockable space to keep possessions should only be denied patients in exceptional circumstances. The Code of Practice requires that hospitals provide adequate lockable facilities (with staff override) for storage of clothing and other personal possessions<sup>33</sup>, but over a quarter of the wards (27%) did not do so in 2011/12

(FIGURE 14).

**FIGURE 14****Provision of lockable spaces for patients, 2010/11 and 2011/12**

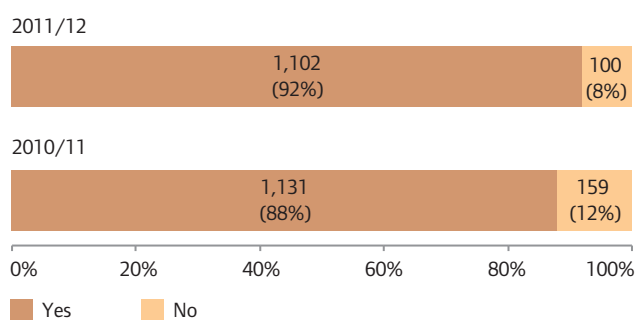
Source: CQC

## Women's dignity and safety

Most of the wards caring for detained patients met Department of Health requirements in having single-sex sleeping areas, toilets, bathrooms and lounges.<sup>34</sup> There was some improvement in 2011/12 compared with the previous year (**FIGURE 15**). However, 100 of the wards CQC visited in 2011/12 did not have adequate gender segregation.

**FIGURE 15**

### Provision of single-sex accommodation, 2010/11 and 2011/12



Source: CQC

In some cases, ward layouts compromised the effectiveness of attempts to provide single-sex rooms, either for want of space or because such rooms were off communal corridors so that, for example, men had to pass women's bedrooms to reach their own facilities. In a learning disability unit, the basic requirements for women's safety and dignity had not been considered:

The unit is mixed and there were times when the Mental Health Act Commissioner saw female patients on their own with all male staff and patients. There is no gender separation apart from bedrooms. There was no evidence to suggest that women had their individual needs met. There was no evidence that vulnerable women were identified and thought about in the day to day running of the unit. There was no evidence that staff were trained to think about women's issues.

**June 2011**

It is Government policy that "there is no acceptable justification for admitting a mental health patient to mixed-sex accommodation" except in a clinical emergency, when a single en-suite room should be provided, a full risk assessment undertaken and complete safety, privacy and dignity maintained.<sup>35</sup>

In exceptional cases, CQC found that the requirement to provide single-sex accommodation effectively led to the long-term segregation of women patients. In January 2012 a MHA Commissioner visited a detained patient who had been the only woman on a low security learning disability ward for several months, during which time she was nursed separately and (partly through choice) did not mix with other patients. The Commissioner required the hospital to provide CQC with plans to have the patient moved to a more appropriate environment which would not require her to be segregated: the care team was working towards a community placement.

## Respecting diversity

Commissioners raised concerns on 36 ward visits that suitable provision had not been made for patients' cultural or religious needs. Detaining authorities should pay particular attention to patients' diverse needs, values and circumstances, to meet both the expectations of the Code of Practice and their duties under the Equality Act 2010. The following are examples of concerns raised:

Patient X is not provided with Halal food in accordance with his religion. As a result, he does not eat a lot of the food provided and relies on cereals. He is prepared to cook some of his own meals in the rehab kitchen, however complains that staff are never available to supervise him there (this was confirmed by staff).

**May 2011**

Patient Y has been on the unit for eight days and has been without a door [to his room]. He is Muslim and felt that his privacy was invaded and his religious and cultural needs were not respected as a result.

**April 2011**

Patient Z raised the issue of the forthcoming festival of Ramadan. Muslim ritual requires that observant patients eat breakfast before sunrise and remain fasting until after sundown. Whilst he was uncertain whether he felt able to fast, due to the stresses of a new medication regime, he was concerned whether a strategy was in place to support the requirements of Ramadan.

July 2011

## The Mental Health Act and citizenship

A parliamentary debate on mental health in June 2012 provided a welcome and refreshing discussion about mental health issues, including mental health and citizenship.<sup>36</sup> The debate touched on a number of issues of discrimination and disadvantage experienced by people who are subject to the Act, all of which had been raised by CQC's predecessor body and some of which are now being addressed.

### Public duties and citizenship

Detention under the Mental Health Act can have a number of discriminatory effects, which are addressed in the Mental Health (Discrimination) (No. 2) Bill 2012-13:

"To our shame ... the law still discriminates against those with a mental health condition. An MP or a company director can be removed from their job as a result of a mental health condition, even if they go on to make a full recovery. Many people who are perfectly capable of performing jury service are disbarred from doing so. If my private Member's Bill is approved by the House, we will look back in a few years' time and be amazed that the nonsense I have described was on the statute book in 2012."<sup>37</sup>

CQC notes the Government's support for this Bill and look forward to its enactment.

### Voting

Traditionally psychiatric service users have been denied the franchise and other rights associated with the exercise of political choice

or influence.<sup>38</sup> From the Representation of the People Act 2000, the legal barriers to detained patients' exercise of the vote have largely been dismantled in the UK\*, although the question of the right to vote for patients who have been transferred from prison remains unresolved.

Research on voting in the last general election across 12 general adult psychiatry wards in Westminster showed that those inpatients who were eligible to vote were half as likely to register as the general population and half as likely to vote if registered. The researchers found that many patients and staff were unaware of the new voting rules, which gave a greater proportion of inpatients the right to vote, and that nine out of 10 patients who were not registered to vote cited a lack of knowledge of their eligibility to vote or of the registration process. Long-stay patients were particularly disenfranchised.<sup>39</sup>

Given that a general election will take place no later than 2015, it is important that detaining authorities prepare now to make sure that those patients detained in hospital are made aware of their entitlement to vote and given assistance to do so.

### Detention under section 136 and criminal records

People can be detained by a police officer under section 136 of the Act on the grounds that they are in a public place and "appears to him to be suffering from mental disorder and in immediate need of care and control". There is no requirement that they are engaged in any activity that is potentially unlawful or even dangerous, although the detention is technically an 'arrest' under the Police and Criminal Evidence Act. Consequently, such detention can show on Criminal Records Bureau checks.

Charles Walker MP raised this question in the House of Commons debate:

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\* The Representation of the People Act 2000 extended the right to vote by post or proxy to detained patients, and the Electoral Administration Act 2006 extended this to enable detained patients to vote in person. See Mental Health Act Commission, *Risk, Rights, Recovery; Twelfth Biennial Report 2005-2007*, 2008, para 2.139

“I am aware of a number of people who have had mental health problems and have been detained for a short while. The police became involved, because they took those individuals into detention or to hospital. They go for a job perhaps as a counsellor or working in the charitable sector. They have a clean record but under ‘Any other relevant information’ [in Criminal Records Bureau checks] the chief constable can say, ‘We are aware that this person was detained for a mental health problem at this institution. We are not aware that they are a threat to adults or children.’ That is that... I am afraid that in our ultra risk-averse world, that is a career death sentence for those people. We need to sort that out.”<sup>40</sup>

CQC supports Charles Walker’s assertion on this issue. In 2008 the Mental Health Act Commission suggested either that Parliament might consider ensuring that section 136 detentions should never count as a criminal record in any circumstance, or that national guidance might provide a presumption that such detention would not be recorded on Criminal Records Bureau checks, only to be overturned in exceptional circumstances.<sup>41</sup> In statutory guidance issued in July 2012 the Home Office states that “on its

own, information relating to physical health or mental health is unlikely to be appropriate for disclosure”.<sup>42</sup> The Quality Assurance Framework (QAF), a set of processes and more detailed guidance covering the disclosure of local police information, provides specific guidance to chief officers on assessing mental health information.<sup>43</sup> This makes clear the circumstances when mental health information can be regarded as relevant.

## School governorship

CQC is pleased to report that amendments to the school governance regulations in 2012 have finally removed the provision whereby a person was disqualified from holding, or continuing to hold, office as a governor of a school at any time when detained under the Act. This provision was subject to specific criticism by the Mental Health Act Commission when the regulations were last revised in 2007.<sup>44</sup>

# 3. Coercion in practice

## Key findings

- The human rights of patients are often affected by controlling practices that only seem to serve the hospital's needs. Hospitals have a difficult task in balancing the realities of detention and compulsory treatment with the requirement that they provide services according to a principle of least restriction on patients. But it has proved all too easy for cultures to develop in which blanket rules deny people their basic rights – especially the right to dignity.
- In one in five visits – an unacceptably high number – MHA Commissioners thought that patients who were in hospital voluntarily might be detained in all but name. For example, in 88 out of 481 visits there were no signs on locked doors that explained to voluntary patients how they could leave the ward.
- On 24 occasions, patients had been secluded but the ward staff had not realised this was classed as seclusion and they had not applied the proper safeguards
- In many hospitals restraint practices are generally safe and appropriate. Almost all staff will now have some degree of training not only in physical methods of restraint, but in ways to prevent confrontational situations.
- However, CQC is still concerned at the lack of regulation of training programmes with regard to restraint. Safeguards could be improved.
- CQC is talking with the Department of Health about how to promote best practice around support for positive behaviour.

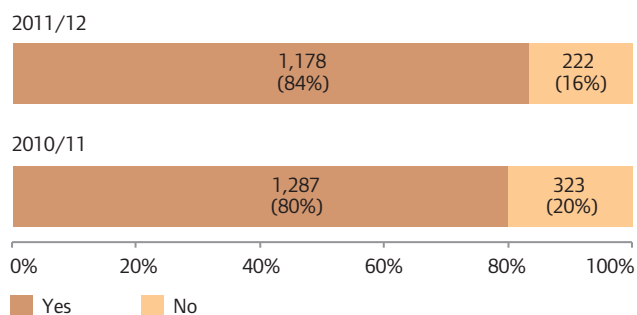
The Mental Health Act Code of Practice sets out general principles that should:

- Limit the use of powers of compulsion so that the minimum restriction is imposed on patients' liberty.
- Ensure that any restrictions are intended to maximise the safety and wellbeing of patients, promoting their recovery and protecting other people from harm.
- Involve patients as far as possible in the planning and delivery of their own care.<sup>45</sup>

These principles also underpin CQC's monitoring of the use of the Act. Keeping to these principles should be part of the development of a recovery focused culture and regard for the human rights of patients. People who are sufficiently unwell to be detained under the Mental Health Act require treatment and support first and foremost. Containment and control should not be allowed to overshadow or undermine this imperative. Thoughtless reliance on blanket restrictions is counter-therapeutic and must be challenged.

## Locked wards

The majority of wards visited in 2011/12 (84%) were categorised as locked wards (**FIGURE 16**). This is a rising trend and has been evident from the start of records in 2004/05. It is not clear why wards are increasingly likely to be locked, although suggested reasons include increasing defensive practices within hospital services and an inpatient population that is more acutely ill by the time hospital admission is undertaken as a last resort.<sup>46</sup>

**FIGURE 16****Locked wards, 2010/11 and 2011/12**

Source: CQC

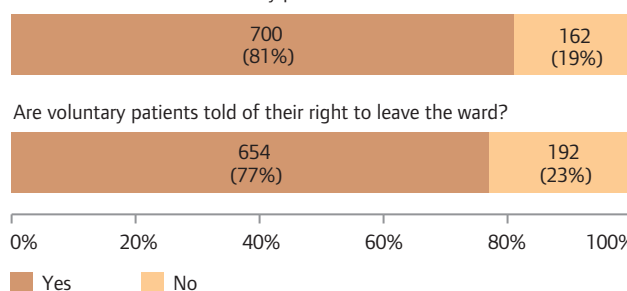
Research has shown that, especially among detained patients, locked doors have negative effects on patients, including depression, frustration, irritation, constraint and low self-esteem, and that there is a potential link between locked doors and adverse patient behaviours fuelled by these feelings. Patients have also said that locking the ward door made staff colder and more controlling.<sup>47</sup>

## De facto detention

In 19% of visits in 2011/12 CQC expressed concern about the de facto detention of voluntary patients – either by physical barriers such as locked doors (**FIGURE 17**), or by staff imposing blanket rules, or by the information given to voluntary patients about the choices available to them.

**FIGURE 17****Freedom of voluntary patients to leave the ward, 2011/12**

Is there evidence that voluntary patients are free to leave the ward?



Source: CQC

Note: No comparable data for 2010/11

Where relevant, CQC raises concerns at the lack of signage on locked doors that would explain how a voluntary patient can leave. In 2011/12, this was a problem in 88 of 481 visits where the issue was relevant – nearly one in five visits. As in the following example, this can be an indication that voluntary patients are not able to leave the ward:

The ward was locked and there were no visible notices by the entrance or anywhere else on the ward to indicate how informal patients could leave the ward if they had the desire to do so. The ward manager was asked what would happen if an informal patient wanted to leave the ward. She said that she would use a holding power to stop patients leaving the ward.

**October 2011**

The Code of Practice states that the threat of detention must not be used to induce a patient to consent to admission to hospital or treatment and is likely to invalidate any apparent consent.<sup>48</sup> While an assessment for possible detention may be appropriate if a voluntary patient decides to leave hospital, the outcome of such an assessment should never be assumed. Voluntary patients should not be told that they would be detained if they try to leave.

Patient 3 approached the Mental Health Act Commissioner during the visit and stated that he was 'illegally detained'. The patient described to us that police had brought him into the hospital in September 2011 in handcuffs but he had not been detained or arrested for this purpose. He told us he was informal but had only been allowed to leave the hospital with a staff escort since he was admitted. The patient said that this is despite repeated requests to be allowed to leave the ward and go home. He also told us that staff had said that he would be sectioned should he actually leave the ward without permission.

**October 2011**

CQC raised concerns over voluntary patients' understanding of their legal status and its consequences in 44 visits in 2011/12. This amounts to almost one in 10 (or over 9%) of



the 481 visits made to wards accommodating voluntary as well as detained patients.

The risks of confusion about the right to leave may be particularly high when patients are discharged from a detention power under the Act but remain on a ward voluntarily.

Patient 4 discharged from section 2 on 29 November. On interview the patient was not aware of the difference between being on section and being informal.

#### **January 2012**

At the time of the visit there were two informal patients in the hospital. Both patients had been discharged from their sections. None of the care planning documentation had changed to reflect their change in legal status. Care plans had been reviewed, but no changes had been made. On one file a s.17 leave form had been completed for an informal patient. An implication may be that staff who do not know the patients (new, agency or bank) would be unaware of their legal status, and thereby prevent them from leaving without legal authority.

#### **May 2011**

CQC has seen examples of staff confusion about patients' legal status. On a visit to a hospital in October 2011, a patient marked as being subject to 'section 5' was included by the ward manager in the count of detained patients provided to CQC. However, it transpired that the patient was not in fact detained under the holding power described at section 5 of the Act, but was an incapacitated patient being treated in her best interests under the Mental Capacity Act, and that 'section 5' referred to that legislation.

One member of staff described the patient as being 'on' a section 5 of the Mental Capacity Act. When the Commissioner explained that no-one can be 'on' a section 5 of the Mental Capacity Act, and that the powers of that act cannot, in any case, authorise deprivation of liberty or detention, the member of staff said that the patient was 'sort of detained'. This demonstrates how potential confusion about the powers of the Mental Capacity Act can be

increased through imprecise use of language to describe patients' legal status.

The following is an example of confusion on a ward about legal status:

Nursing staff did not know the correct legal status of several patients on the ward. The ward board showed some patients with blank legal status and some patients who were listed as detained were in fact informal and vice versa. This has legal implications for the trust in potential breaches involving consent to treatment and basic human rights. Two patients were marked up as detained on the ward board in the morning but only after further checking involving Mental Health Act staff did nurses realise they were informal. Without the visit it is not clear when (or if) their actual legal status would have been established.

#### **January 2012**

From a patient's perspective, containment without just cause or proper authority is extremely distressing. In preventing voluntary patients from exercising their rights, services not only act unlawfully but could also exacerbate patients' distress so that (otherwise avoidable) formal detention follows.

### **Locked doors within wards**

Initiatives to promote therapeutic engagement and recovery may include arrangements where patients are expected to be in certain parts of a ward or hospital at certain times of day. Zonal nursing systems, which involve locking off rooms or areas within wards, were originally designed for use in medium secure units for patients exhibiting risks of suicide or self-harm, and in some circumstances may enable less intrusive nursing of patients who would otherwise require one-to-one observation.

But zonal systems have also been used in units that are not designated with any particular level of security to restrict patient movements to a high degree:

All doors were operated by a swipe card held by staff. The main patient area has a quiet room; this was also controlled by swipe card and was locked on the morning of the visit. The patient toilet was also locked and the Commissioner observed a patient requesting to use the toilet and having to wait while the swipe card was activated.

#### October 2011

In the following example CQC asked for an urgent review into the evidence base and appropriateness of zonal nursing and the automatic locking of internal doors in a brain injury unit:

The Commissioner was unclear about the evidence base or appropriateness of zonal nursing for this client group in the environment provided, particularly as the rooms in which patients spend most of their daytime, i.e. the lounge and the dining room, are locked to prevent patients leaving. It is felt that this could potentially be perceived as seclusion.

#### August 2011

In response, the hospital told CQC that zonal nursing had been introduced as a pilot on the ward in question and that, on review and taking account of CQC's comments, the pilot was stopped so that "the ward will use the environment in a more flexible and less restricting manner, which will be responsive to the changing needs of the client group".

In some cases, locked internal doors appear to patients to be symptomatic of a generally restrictive environment. In the following example, patients raised concerns about rigid rules that allowed smoking only at set times of the day, and other restrictions that they said were unnecessary:

The quiet room and activity rooms are kept locked and patients need to ask staff for access. Although staff said this was for the management of risk, patients had free access to their bedrooms which are next to the quiet room. There does not appear to be a rationale for this. The rooms are little used.

#### January 2012

The trust defended its practices as necessary for maintaining a safe environment in a forensic setting, but CQC will continue to monitor this carefully.

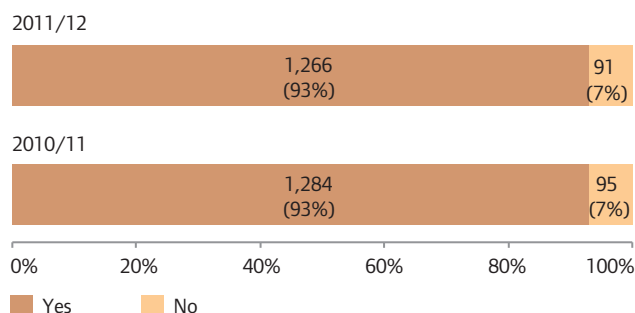
## Access to bedrooms

Patients are sometimes not allowed to access their bedrooms during some or all of the daytime. CQC found restrictions on patients' access to bedrooms in 7% of visits, the same proportion as in 2010/11 (**FIGURE 18**).

**FIGURE 18**

### Patients' access to their bedrooms, 2010/11 and 2011/12

Do patients have access to their bedrooms during the day?



Source: CQC

In general CQC tries to encourage hospitals to allow some flexibility, so that they can be varied depending on individual patients' risk assessments. In the following example CQC asked the hospital to rebalance the needs of individual patients with the management of the ward:

Patients have restricted access to their bedrooms during weekdays. Whilst we understand the aims of the ward staff to encourage patients to engage in therapeutic activities it is unclear how this blanket policy is consistent with providing care based upon the individual needs of each patient. For example, patient 5 on interview stated that she finds it difficult to get up in the morning because of the sedative effects of her medication, this also means that she is often very sleepy during the day and requires the privacy of her bedroom.

#### October 2011



BB Now it's about more involvement – no decision about me without me – but when they make these blanket rules on the ward it undermines that. Like when you're not allowed to access your room during the day – some people like to relax and be in their own company and own space – they're grown men, they can't see why they can't go to their room whenever they want DD

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#### Service user detained under section 47/49

The intended therapeutic purpose of requiring patients to be in communal areas during the day can be undermined if patients are not provided with meaningful activities and there is no quiet area on the ward:

Some of the patients raised concerns about the recently introduced initiative of patients not allowed room access between 10 a.m. and 1 p.m. and between 2.30 p.m. and 6 p.m. One of the patients stated that this was affecting his mental state very badly. He went on to say that there is nothing to do during this time except for sitting in the day room with a group of strangers, watching TV which is often very loud. He went on to say that there were no therapeutic activities at all on the ward for the patients.

**January 2012**

Where hospitals feel the need to prevent patients from staying in their rooms for long periods, they should therefore consider whether the ward is offering sufficient meaningful and interesting therapeutic activities, and whether it is a pleasant place to be, during the day. It would be better to address this and provide patients with a positive reason to engage with the daily life of the ward, rather than reinforce patients' sense of privation by locking them out of their rooms.

In the following example, the individual tailoring of a care plan, and the patient's involvement in the development of that plan, puts restrictions on bedroom access into a meaningful context for the patient so that they were not perceived as a deprivation:

BB I have a current care plan which states that if I feel or appear to be unsettled in my room then I have to come out my room where staff can keep a closer eye on me. I don't mind this as I helped to make this care plan. DD

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#### Service user detained under section 3

CQC expects that hospital policies will ensure that interventions designed to prevent patients remaining in their bedrooms during daytime:

- Are flexible to individual patients' needs.
- Address whether the ward environment and therapeutic programme provide positive reasons for patient engagement in the life of the ward.
- Are considered in parallel with patients' experiences and views on the unwanted side effects of medication.

## Night-time confinement in the high security hospitals

In CQC's last report it highlighted its concerns at plans to reintroduce night-time confinement of patients to their bedrooms as a cost-saving measure in Rampton High Security Hospital.<sup>49</sup> During 2011/12, only Rampton Hospital was piloting night confinement on this basis, but the other hospitals are considering wider implementation. CQC has heard at least one of the high secure hospitals express the view that night-time confinement helps to use resources equitably, and as such is consistent with the effectiveness, efficiency and equity principle of the Code of Practice.

On visits to Rampton Hospital this year, MHA Commissioners continued to meet with patients who were concerned about the idea. On two women's wards, patients were afraid that being locked up alone at night would increase their self-harming behaviour, and/or lead to their rooms being stripped of possessions to prevent opportunities to self harm.

Patients fear that the introduction of night time confinement onto their ward will lead to an increase in self harming as many say they find time alone extremely challenging yet do not wish to sleep in rooms stripped of their possessions. Staff were unable to provide reassurance about this.

### December 2011

Some patients expressed serious concerns about how being locked in their rooms at night might impact on their mental health. One patient wept when describing how she finds it difficult to tolerate being locked into a room as it brings back memories of the abuse she suffered as a child. When she has been secluded she has struggled and relied heavily for support on maintaining contact with the observing nurse.

### February 2012

The trust said that patients will be individually risk assessed and observations, support and reassurance provided as required throughout the night, and that removal of belongings will be done

on an exceptional basis, just as it was before the night confinement. As stated in CQC's last report, meeting these assurances with reduced night staffing may be a challenge for the hospital and CQC will continue to monitor this closely.

The trust also said that patients will have access to a drink and a snack in the night. In a visit to the hospital in summer 2011, CQC raised the issue of access to water for patients subject to night confinement under the security directions, or subject to room confinement after returning from the gym. A policy there said that only half a litre of water could be taken into patient rooms to avoid larger bottles being used as weapons. The hospital agreed to be more flexible and allow alternative arrangements (such as taking more than one smaller bottle into rooms).

## Confinement to bedrooms

In visits to hospitals, MHA Commissioners look out for institutional living arrangements that may result in people being confined to their bedrooms earlier in the day than they would like. Commissioners raised concerns about this issue on 12 visits in 2011/12.

CQC found four further examples in its themed inspections of learning disability services, all of which provided care for people detained under the Mental Health Act.<sup>50</sup> Patients in a specialist learning disability hospital told CQC that they were expected to go to their bedrooms by the staff changeover at about 8pm and that they were in effect confined to their bedrooms from this time, with bedroom doors closed and door alarms activated. Although the hospital disputed this, it did extend staff hours so that more staff were on duty until 9pm, and assured CQC that they had talked with patients about 'bed times' and would monitor the matter through feedback from weekly house meetings.

## Encouraging least restrictive practice

The Code of Practice establishes as a guiding principle that people taking action without a patient's consent must attempt to keep to a

minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.<sup>51</sup>

Alongside the MHA, the Mental Capacity Act 2005 (MCA) provides a statutory framework for protecting the interests of people who lack the mental capacity to make their own decisions. Essentially the MCA formalises and improves the 'common law' position that had previously grown up through case law over many years. The MCA also takes as a principle that any act or decision must be taken in a way that is least restrictive of a person's rights and freedom of action.<sup>52</sup>

Hospitals have a difficult task in balancing the realities of detention and compulsory treatment with the requirement that they provide services according to a principle of least restriction on patients. There is always a danger of institutionalisation when the perceived needs of the institution are prioritised over the needs of patients themselves.<sup>53</sup> A key role of the MHA Commissioners as visitors to places of detention is to challenge this process.

It has proved extremely difficult to prevent cultures developing within which the rights of the patient are adversely affected by a range of practices that appear to serve only institutional ends (such as managing staff shortages) and to be enshrined in custom. Inflexible approaches may be disempowering and demoralising not only for patients but also for those who care for them on a daily basis. The implementation of the MCA provides a new framework within which to address some of the practical challenges of caring for people with complex needs.

The Star Wards survey report of 2009/10 found that "a small but significant number" of staff surveyed "mentioned barriers created by hospital rules, regulations and culture" to the implementation of the Star Wards programme.<sup>54</sup> While these are not the only barriers to developing a better culture on wards – two-thirds of staff responding to the survey reported more practical barriers including staffing levels or skill mix, hospital environments and other resource issues – they are nevertheless ones that a focus on human rights and least restrictive practice could most easily address.

## Hospital rules and practices focused on control

In some of their visits, MHA Commissioners heard staff explain restrictions placed on patients in terms of an explicit therapeutic purpose. This may be entirely appropriate in the context of an individual care plan to manage risks resulting from a patient's illness.

However, when presented as a form of treatment in itself, the resulting restrictions on people's human rights are more worrying, as in the following example:

Women patients in a forensic unit, visited in November 2011, were subject to a 'staged programme of care' where 'privileges' had to be earned by displaying controlled behaviour. Thus patients were initially subject to restrictions on access to fresh air, food and drink, bedrooms (including bedding), the activity room, smoking, personal possessions and other patients on the ward. CQC found that decisions about restrictions were not always based on risk and were not individualised. Such restrictions could be perceived as institutionalised, punitive in nature and even dehumanising. CQC has been promised systemic change by the hospital managers and will monitor progress carefully.

Hospitals considering the use of such behaviour modification programmes can no longer find explicit guidance on them in the Code of Practice, as revised in 2008. The previous edition of the Code recognised that some psychological treatments interfere with patients' basic human rights and stated that no one should be deprived of food, shelter, warmth, a comfortable environment, confidentiality or reasonable privacy as a consequence of behaviour modification programmes<sup>55</sup> and that interventions should be individualised, subject to discussion and review by the whole clinical team and that patient's consent should be sought even if a refusal may be overridden.<sup>56</sup> It may be helpful to reiterate this guidance in the next edition of the Code, or otherwise stress that the guiding principles now underlying the Code should not be suspended when implementing behaviour modification programmes.

MHA Commissioners observed in some hospitals that policies seeking to manage the risks associated with mental disorder are similarly unresponsive to the individual needs of patients. In one hospital, the observation policy required night staff to check on all patients' wellbeing throughout the night, which they did by shining a torch through their bedroom door observation windows. Some patients did not appear to warrant such intrusive care and found this very disruptive. One patient in particular said that, although not deemed at risk of self-harm, he was woken by the torch every hour and had not had an unbroken night's sleep since arrival.

The MHA Commissioner challenged the trust to justify such practices and, after some discussion, the policy was changed to require such observation only where an individual risk assessment merited it. This example shows the importance of keeping institutional rules under review and ensuring that they are connected to real-life requirements. Initially the trust said that a one-size-fits-all approach to observation practices was supported by staff. But when the MHA Commissioner spoke with staff, they could not identify any professional who thought the practice to be appropriate. Indeed, the doctor of one patient stated that there would be no risk were night-time observations discontinued in his case, and yet that patient's complaint to the trust about being woken without justification was rejected by them on the grounds that the practice was trust policy.

In the following examples, the institutional response to perceived risk appeared irrational.

In June 2011, CQC visited a medium secure unit where blanket restrictions on patient possessions were being enforced following an incident of patient violence. The following describes the consequences of this for one patient who was not involved in the incident:

Patient 6 is a keen painter and his ability to paint has been compromised by the reduced access to his painting equipment which had previously been kept in his room. He now has access to some equipment and can swap this for other items at weekends. The Mental Health Act Commissioner queried with staff

the rationale for allowing him to have a few pencils rather than the whole set, or a few paint pots rather than the whole range. One reason given was that the paint pots could be used as a weapon, but the Commissioner pointed out that as he was allowed some paint pots these could be used as a weapon in any event. Patient 6 now feels that his ability to pursue his hobby is compromised and he feels that this is a retrograde step. We were concerned that the rationale for removing so many items was more for staff convenience and not taking account of the rights of patients, blanket restrictions being applied due to the actions of other patients.

#### **June 2011**

In this example, the patient's experience of powerlessness was increased by lack of information. At CQC's request, he was provided with access to the Code of Practice and Medium Secure Unit commissioning guidelines, and the hospital undertook to produce a patient leaflet explaining its search policy.

In a different hospital, CQC found that:

One patient is only allowed to play the guitar for a half hour each day with a member of staff present. Whilst we recognise that a guitar could be used as a weapon and the strings taken off and used as ligatures, the patient had not been risk assessed to ascertain whether he would do this. It would seem better both for the patient and to reduce demands on staff to assess him to see if he can be allowed his guitar unsupervised. Similarly, the patient is allowed a pencil in his room until midnight but must then return it. It must be asked what he could do after midnight that he could not do before. Staff response was that he might stay up all night doing his puzzles. This seems to be a separate issue and needs to be addressed separately. Requiring him to return the pencil is demeaning and treating him like a child. The Commissioner has observed a culture within the medium secure service of blanket policies which are not always warranted and staff do not challenge them enough.

#### **June 2011**

## Withholding of mail and telephone monitoring in the high security hospitals

The high security hospitals have legal powers to withhold mail addressed to, or from, a patient in their hospitals if its content is likely to cause distress to anyone (excepting any member of staff) or cause danger to anyone.\* They may also record and monitor a patient's telephone calls if there is a need to protect the safety of the patient or others.<sup>57</sup> Communications with certain bodies – including CQC, members of parliament, and patient's legal representatives or advocates – are excluded from these powers and can be neither intercepted nor read.<sup>58</sup> CQC has a legal power, on receipt of an appeal against the use of these powers, to direct that mail be released to its addressee or telephone monitoring cease.<sup>59</sup>

Table 4 shows the number of appeals received by CQC since 2009 against withholding of mail or telephone monitoring. Two-thirds of the appeals (22) originated from Rampton Hospital. In CQC's view this reflects well on that hospital's culture regarding withheld mail and telephone monitoring, and shows that patients are aware of their right to appeal and feel free to exercise that right. CQC has had an excellent

response from the hospital to its decisions and recommendations, which have been reflected in training and practice at the hospital.

The high security hospitals should ensure that all staff are aware of the law as established by the primary legislation and regulations. During the year, CQC found that one doctor was unaware of the regulations regarding rights of appeal to CQC over items withheld from the hospital's internal postal system, and was thus advising patients that they had no such right of appeal. CQC also became aware that staff were operating under an assumption that the withholding of any postal package containing items prohibited under hospital policy was not subject to review under section 134 of the Act, and consequently patients were not informed that they could appeal to CQC over such withheld packages. They were told that they could only ask for a review of the decision by the clinical team and/or hospital security department.

The hospital accepted without argument CQC's challenges that these approaches were wrong in law and therefore denying patients a statutory right of appeal. Practice has subsequently changed. In relation to withholding mail containing banned items, CQC does of course recognise that the hospital is both entitled and expected to prohibit certain items as a blanket security measure, and it takes account of this when considering any appeal. However, because the prohibited item may not be the only content of a package that is withheld, CQC does not think that the protections offered by a right of appeal can or should be suspended when there are prohibited items involved.

\* In relation to mail received into or sent from the hospital, under the powers of Mental Health Act 1983, s.134(2). Internal post may be withheld from its intended recipient under the criteria described above, and also if "it is necessary to do so in the interests of the safety of the patient or for the protection of any other person" (*The High Security Psychiatric Services (Arrangements for Safety and Security in Ashworth, Broadmoor and Rampton Hospitals) Directions 2011*, regulation 27(3)).

**TABLE 4**

**Appeals against decisions to withhold mail or monitor telephone calls in the high security hospitals, 2009/10 to 2011/12**

	2009/10		2010/11		2011/12	
	Mail	Telephone	Mail	Telephone	Mail	Telephone
Hospital decisions appealed	8	1	6	3	13	1
Hospital decisions upheld	3	0	5	3	10	1

Source: CQC



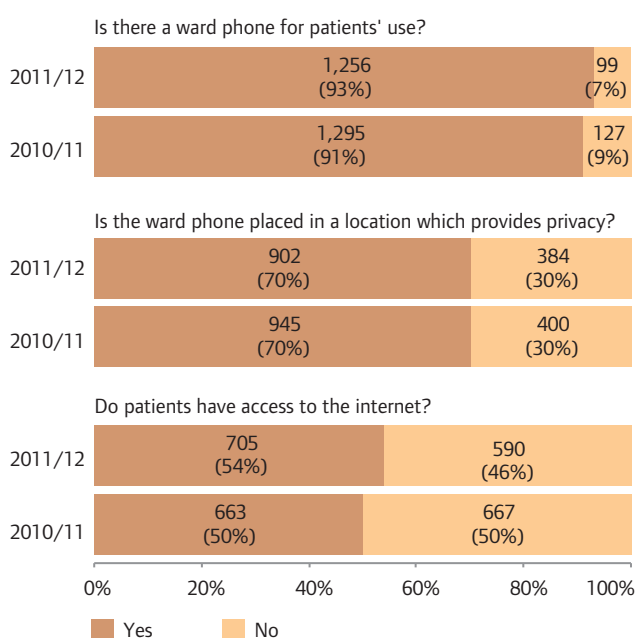
It is important that all staff potentially involved in making decisions about withholding or monitoring communications (including responsible clinicians) receive training on the legal criteria for intervention. CQC has observed that, without such training, staff may ‘err on the side of caution’ and make decisions that are not defensible in law. Such training is also needed to ensure that the reasons for withholding or monitoring communications are adequately recorded. Where monitoring is initiated on grounds of risk, patients should normally expect to be informed not only of the reasons for such monitoring, but of what they could do for it to cease.

## Access to telephones and the internet

CQC found that there was no ward telephone accessible to patients on 99 visits in 2011/12 (**FIGURE 19**). This is a smaller number than in the previous year, but CQC can see no justification for having no access to a landline phone in a hospital where patients may be detained. CQC seeks to ensure that all wards have an accessible phone.

**FIGURE 19**

**Patients’ access to telephones and the internet, 2010/11 and 2011/12**



Source: CQC

Almost a third (30%) of the landlines for patient use in hospital wards were deemed by MHA Commissioners to provide inadequate privacy. Typically, this is because they were in a communal space or corridor and not fitted with a booth or hood as suggested by the Code of Practice.<sup>60</sup> In one case, the only telephone available to patients was in the nursing office, which was unacceptable not only because it compromised patients’ access to the telephone and privacy, but could also risk compromising the confidential information that is kept in a nursing office.

Any policy that restricts a patient’s access to a phone or ability to communicate over the phone with privacy must be consistent with the patient’s right to respect for his private life and correspondence under Article 8 of the European Convention on Human Rights.<sup>61</sup> The Code of Practice states that:

“The principle that should underpin hospital or ward policies on all telephone use is that detained patients are not, of course, free to leave the premises and that individual freedom to communicate with family and friends should therefore be maintained as far as is possible. Any restrictions imposed should be the minimum necessary, so as to ensure that this principle is adhered to.”<sup>62</sup>

The Code also states that it is unlikely to be appropriate to impose a blanket ban on mobile phone use by detained patients, except in units that are specifically designed to provide enhanced security for public protection.<sup>63</sup> CQC found six instances of blanket bans on mobiles in units that do not fit this criterion. In the following example CQC required a review of a blanket ban on mobiles:

Patients are no longer allowed to have a mobile phone on the premises. This is a particular concern for patients on the admission ward, who do not have leave. One patient had a mobile phone contract which he was unable to use. Furthermore, the payphone located in the corridor is not private and conversations can be heard in the sitting area. It is acknowledged that, for one patient, outgoing calls needed to be supervised to ensure that he did not dial

a particular number. The risk presented was appropriately documented in his care plan. The Commissioner noted on a previous visit that the practice was to keep mobile phones in the office, but to allow patients to use them in the privacy of their own rooms.

#### **August 2011**

CQC raised concerns about blanket policies over phone use on 24 visits in the year.

In the rehabilitation unit managed by the trust in the example above, CQC also found a 'contraband list' of banned items, which included mobiles and cigarette lighters. CQC was told that the unit was initially taking a cautious approach to security issues, but in its view this was not consistent with the principle of least restriction and it was concerned that such institutional restrictions could become embedded in practice. Especially in rehabilitation units and other wards at the lesser end of the security spectrum, restrictions on patients' access to such items must be made on the basis of individual risk assessments, be proportionate and meet the Code's expectations.

The Code of Practice requires hospitals to have a policy on patients' access to the internet, which many people now use as a means of communication with friends and family.<sup>64</sup> In 2011/12, 54% of all wards that CQC visited provided access to the internet, a slight improvement on the previous year's figure of 50%.

Many patients' mobile communications will include access to email and the internet, although in some services the use of such devices may be restricted because of their camera functions, to protect other patients from potential violation of their privacy. However, the Code of Practice assumes that such restriction will not take the form of an outright ban, but rather that confiscation of mobiles is likely to be appropriate where patients consistently refuse to comply with the ward rules over their use, and that such rules might restrict the use of mobiles to certain areas of the hospital.<sup>65</sup>

## **Monitoring of phone calls in hospitals other than high security hospitals**

In this reporting period CQC challenged one hospital over the legal basis for its monitoring of phone calls in an adolescent ward. The hospital's own legal advice is that the power to undertake such monitoring could be found in the House of Lords decision in the *Munjaz* case, where it was held that hospitals had the power to control the activities of detained patients, subject to acting proportionately and in their best interests.<sup>66</sup>

CQC has some concern over this stance. The Secretary of State for Health has expressly provided powers to monitor telephone communications to the high security hospitals through its passing of the High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011. No such provision has been made for lower security detention. Any telephone monitoring powers assumed by other detaining authorities would not be subject to the statutory safeguards established in the Security Directions. CQC would welcome clarification of this matter, and for the next edition of the Code of Practice to provide a clear statement of the limits of powers to monitor telephone communication by detained patients.



## Searching patients

The Code of Practice states that search policies may extend to routine and random searching of patients without cause only in exceptional circumstances, such as where patients in a particular unit “tend to have dangerous or violent propensities which create a self-evident pressing need for additional security”.<sup>67</sup> This criterion appears to be interpreted rather broadly in some services, where searching is routine when patients return from leave:

The Commissioner recommended on a previous visit that the hospital should review its practice of routine searching of all patients on return from leave. The Commissioner was told that there are requirements with the low secure commissioning contract to conduct a percentage of searches, but this does not necessitate a blanket policy of searches, particularly of patients who are passing through the rehabilitation programme.

### July 2011

All patients, some with long periods of leave, are subject to escorting to and from the ward to the main entrance to the unit – often with a wait for staff to become available. They are also being routinely searched on return to the unit.

### November 2011

CQC does not expect the low secure services commissioning guidance, currently still in draft following Department of Health consultation with stakeholders, to specify requirements for specific levels of routine searching.<sup>68</sup> While it may be appropriate to establish routine searching from time to time, CQC expects that this will be achieved with reference to the Code’s specific guidance on searching and in accordance with its general principles, including the principle of least restrictive practice.

## Seclusion

The Code of Practice provides detailed guidance on the safeguards that should be applied to patients who are subject to seclusion (defined as supervised confinement in a room).

It states that all episodes that can be defined as seclusion should merit those safeguards, which are primarily systems of clinical review and monitoring.<sup>69</sup> Services that follow the Code’s guidance generally demonstrate good practice with regard to seclusion.

On 24 separate occasions this year, CQC found that seclusion practice was not recognised as such, and that the Code’s guidance on safeguards has not been followed:

Ward x has a quiet room which is used to de-escalate situations and to enable patients to calm down. This room is padded to prevent a current patient with a tendency to head bang from injuring himself. The Mental Health Act Commissioner was shown a form that patients are asked to complete to write down why they have been asked to use the quiet room. The Commissioner was concerned whether the practice could amount to seclusion without the appropriate safeguards as set out in the Code being met.

### June 2011

On a further 21 visits, while seclusion was recognised, there were inadequate safeguards of review. The Code’s guidance is that a doctor should attend immediately unless the seclusion is for a very brief period<sup>70</sup>:

Examination of the available seclusion documentation revealed that out of a total of nine separate episodes of seclusion, a doctor attended in only two cases (one of which was the attendance of the doctor two hours after seclusion had ended)

### January 2012

On a number of occasions it appeared that, where seclusion had been initiated by a nurse in charge, no doctor had attended for a number of hours. In one instance the seclusion commenced at 9.10, a doctor was called at 9.15 but did not attend until 13.30, thirty minutes after the seclusion had been terminated.

### December 2011

“When I have been secluded I believe it has been mostly done for the right reasons i.e. for my own protection as well as for the safety of others. But at times I felt that it hindered my recovery, in that when I felt calm I was still kept secluded. This was probably because the ward I was on was short staffed.”

**SURP member detained under section 37/41**

In another example, a patient remained in conditions of seclusion for 43 hours, subject to inadequate review. The seclusion episode had started at 17.00, and the doctor had written at 19.00 “to remain in seclusion overnight and review in the morning”. The next entry by the doctor was at 13.50, nearly 19 hours after the start of the seclusion, and the patient remained in the seclusion room until 20.00 hours that day. However, after leaving the seclusion room the patient was nursed on 2:1 observations in his room, taken out to the garden for smoking breaks alone, and was not allowed to mix with other patients until 14.00 the following day. There was no obvious case for not applying the Code’s guidance and respecting the rights of the patient.

CQC found that some seclusion environments were inadequate, failing to meet the Code’s guidance that rooms should be adequate in furnishing, heat, light and ventilation. In the following example, a ward policy of only providing a mattress during the night fell short of this.

One service user was secluded for eleven and a half hours before being given any seclusion furniture despite several requests for a mattress and complaining of back pain. Seclusion records showed that this particular service user was calm and settled with the exception of a period of door kicking when his requests for a mattress were continually refused.

**March 2012**

The above example demonstrates how, in some cases, the conditions of seclusion may exacerbate the behaviour that led to the seclusion. In this case, seclusion continued for longer than could be justified: the adolescent patient’s care plan stated that the minimum requirement for the termination of seclusion was 24 hours of settled behaviour, which is itself a breach of the Code’s expectation that seclusion be maintained for the shortest possible time.<sup>71</sup>

Some examples of poor seclusion environments could compromise patients’ dignity:

The seclusion room is in need of urgent refurbishment. Part of the rubber wall coating has come away, the sink needs to be assessed with regards to potential self-harm, the room smells of urine and there is no clock available for patients to see.

**June 2011**

The seclusion room consists of a basic room containing a mattress on the floor. There is no toilet or washing facilities and a patient held there would find it difficult to see the clock which is on a wall away from the seclusion room. When questioned on what would happen if a patient required the toilet whilst in seclusion, staff informed the Commissioner that bedpans would be supplied.

**September 2011**

On 17 visits CQC found that there was no clock clearly visible to patients in seclusion. This can be very disorientating, particularly over longer periods. On each occasion CQC asked for this to be rectified straightaway. On another visit, staff said that they had a portable clock: one staff member said that they “try to remember” to place this within sight from the seclusion room; another said it was placed there “when needed”. A clock is always necessary and should be a fixture visible from the seclusion room.

The Code of Practice states that seclusion should never be used solely as a means of managing self-harming behaviour.<sup>72</sup> In the following examples, the use of seclusion breaches this guidance and is far removed from the exemplary scenario set out in the Code:<sup>73</sup>

BB I ran off from a medium secure unit and was apprehended by the police and put in a custody cell for the night. I was so distressed due to past experiences in cells that I bashed my head repeatedly against the wall. When I was transferred back to the medium secure unit I was traumatised and very unwell and distressed. I tried to continue hitting my head against the walls and the decision was made to put me in seclusion. Of course I continued to bash my head and there was nobody to prevent me from hurting myself. A doctor was called and I was taken to hospital where a scan revealed a haematoma to the brain. I believe it would have been better to restrain me than leave me alone and distressed in seclusion where I continued to cause damage to myself. Some people have a fear of small confined places and I am one of them. DD

**Service user detained under section 37/41**

BB I have been in seclusion and found it very depressing. It was old style seclusion and reminded me of an empty cell with a mattress on the floor. There was nothing to distract you or keep you occupied, which fuelled my illness as I had no-one to communicate with and so had all the time in the world to feed into my psychosis. DD

**Shaun, service user detained under section 47/49**

Irrespective of patients’ clinical presentation when entering seclusion, hospitals should ensure that they comply with the Code of Practice requirement to provide “care and support rendered necessary by their seclusion both during it and after it has taken place”. It should be assumed that some form of support or debriefing for patients may be necessary when they emerge from seclusion, and that the act of isolating a patient is likely to do some harm.<sup>74</sup>

## Restraint

In many hospitals restraint practices are generally safe and appropriate, and almost all staff will now have some degree of training not only in physical methods of restraint, but also in ways of providing relational security that can disarm potentially confrontational situations:

BB When I came from prison to this place there was a confrontation and I thought that they’d press all the buttons, they’ll be a big fight and I’ll end up in seclusion – but they didn’t do that, they handled it really well and said “we’re not going to press the button” – and it really confused me! Where I’d come from they’d have jumped on me a long time before. That’s when I realised this place is a bit different. DD

**Service user detained under section 47/49**

Where physical restraint is done well, it can be seen as a positive intervention by patients.

BB Whilst I was sectioned between 2009 and 2011, I was restrained for my own safety and was put in full restraint on the floor. What I found good was that they told me what they were doing and only one member of staff took lead of the restraint so it was only one person talking to me and taking control, rather than everyone trying to take control and talking over each other. I found that this helped me calm down a lot quicker than everyone shouting at once and felt that the restraint was fully controlled and over as quickly as possible without distressing me further. DD

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#### Service user detained under section 3

Nevertheless, CQC continues to be concerned at the lack of regulation over training programmes with regard to restraint, and feel that safeguards could be improved. CQC had concerns about the recording and monitoring of restraint practices in a quarter of the 150 hospitals and care homes for people with a learning disability that it visited following the BBC Panorama programme on abuse at Winterbourne View.<sup>75</sup>

BB When I was restrained – because of my breathing – I found it really difficult. They put you face down and people like me cannot breathe properly. It was a really horrible experience. DD

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#### Danuta, service user detained under section 37

### Restraint and patient abuse

The serious case review into Winterbourne View documents the “continuous possibility of harm and degradation” that hung over its patients through the use of disciplinary powers to punish and diminish them.<sup>76</sup> Much of this abuse went under the guise of restraint.

CQC treats all concerns about potentially abusive restraint very seriously and engages safeguarding procedures where appropriate. The review was critical of CQC’s effectiveness in ensuring that concerns raised by a MHA Commissioner in September 2010 were followed up and appropriate actions taken.<sup>77</sup> CQC’s own internal management review of October 2011 noted that evidence from MHA Commissioners and Second Opinion Appointed Doctors is increasingly an integral component of its evidence informing regulation, but that processes underlying exchanges of information between MHA Commissioners and compliance inspectors needed to be reviewed and embedded.<sup>78</sup> CQC has continued to work on this and now ensures regular contact and joint visiting between MHA Commissioners and compliance inspectors.

Concerns about potentially abusive restraint practices were raised on a small number of visits (for example, patients alleged inappropriate or abusive restraint in only eight cases during the year, six of which CQC was unable to substantiate).

When visiting a learning disability unit in June 2011, CQC was already aware of allegations of abuse and assault that had, in some cases, led to disciplinary action against staff. On the day of the visit, the MHA Commissioner asked patients directly whether they had been assaulted or treated badly by staff. It was reassuring that patients were open in their response, and that all of the incidents raised were already known to the management team and had been investigated.

But some of the allegations were very serious, such as one where it was said that a staff member had assaulted a patient, overturning his bed and trapping him under it. CQC was also concerned that one patient who had been active in raising complaints regarding staff members' inappropriate behaviour said that she had been called a "little bitch" by some members of staff.

CQC required the hospital to investigate this and ensure both that the patient was supported to raise her concerns with a person of her choice and that no patient or other whistleblower could be victimised. CQC also required full details of all disciplinary actions taken against staff from the start of the previous financial year. The complaint was investigated by police and referred to safeguarding.

## Poor practice in restraint

Cases where restraint practice is poor but not malicious may also be abusive, or be perceived as such by patients.

Where CQC has concerns at levels of restraint, or patients raise concerns about restraint practice with us, it may seek assurances about the following:

- Are there always sufficient numbers of qualified staff to initiate de-escalation?
- Do attempts at de-escalation continue throughout the restraint?
- Are patients properly debriefed after a period of restraint?
- Is restraint properly and regularly reviewed, and are the patients' views sought on the possibility of alternative actions that might be taken to manage behaviour?

- Are all staff, including bank staff, properly trained in control and restraint, and do any staff members have any concerns about being able to keep patients safe in such interventions?
- Where patients raise concerns, is the hospital's safeguarding lead aware of patients' views?
- Are the hospital managers assured that any concerned patient knows how to contact the independent advocate and CQC whenever necessary?

Our national inspection programme of learning disability services found major concerns in the use of restraint in this sector, especially relating to the effective monitoring of restraint episodes, and learning from the results.<sup>79</sup> Most hospitals that detain and treat patients under the Act specialise in mental health rather than learning disability services, but similar concerns have been raised in some MHA Commissioner visits in a range of detaining authorities.

In a learning disability unit visited in June 2011, the MHA Commissioners were concerned about levels of restraint and restraint practice. They found that local incident forms were not always properly completed, and that the ward manager was unable to supply details of restraint incidents over the week and month prior to the visit. There was no evidence that patients were talked to after restraint incidents, or that they had an opportunity to discuss their subsequent care plans. The Commissioners were concerned at the low levels of therapeutic activity on the ward, as incidents are likely to be more frequent when patients are bored, and concluded that restraint was neither reported nor monitored in a robust way. The unit is now closed following CQC's withdrawal of its registration.

## Staff training in restraint

Staff need to have the appropriate skills to manage disturbed or violent behaviour in psychiatric inpatient settings, and should receive training in line with NICE guidelines.<sup>80</sup> The Code of Practice requires that staff who attend training in the recognition, prevention and management of violence and associated physical skills to attend periodic refresher training.<sup>81</sup> Some staff



on a learning disability unit visited in January 2012 had not received refresher training for two to three years, or not at all since their initial training, even though there were high numbers of incidents of violence or aggression on the unit. CQC found no risk assessments for patients who were restrained regularly, and one patient interviewed had a sore knee and complained that some staff had put painful pressure on her shoulder, arms and legs during restraint and had to be told to 'ease off' by other staff.

CQC asked for training to be provided; risk assessed care plans to be completed; an analysis of restraint incidents to be provided; and for the hospital to address its safeguarding procedures. The hospital arranged for conflict management trainers to visit the ward over several days, assess staff interaction with patients and also look at de-escalation and proactive strategies in managing challenging behaviours. In another unit there had been no training on managing aggression or violence in the year prior to the visit, although in the six months before the visit there had been two serious assaults on staff, one of which had led to lengthy sick leave following an attempted strangulation.

Research suggests that "success stories consistently demonstrate the importance of staff training to help reduce overall rates of restraint and seclusion, inappropriate use, and staff and patient injury".<sup>82</sup> There is scope for standardisation and accreditation of such training to ensure that it is comprehensive, for example in meeting the following suggestions arising from research:

- Training must give sufficient emphasis to verbal crisis management and de-escalation techniques as well as to methods of physical restraint.
- Just as staff must be trained to identify 'red flags' of escalating behaviour in patients, they should also be trained to recognise warning signs (anger, indifference, impatience, fear, or judgment rather than empathy) among themselves and their colleagues.

- Patients and, where appropriate, relatives and carers need to be involved in staff discussions over individualised strategies for managing aggressive behaviour or enforcing compliance with treatment.
- Repeated training in restraint and seclusion protocols is needed so that staff are continually reminded of positive behaviour practices and remember what to do when an incident arises.

CQC continues to work with the Independent Advisory Panel on Deaths in Custody, both in sharing concerns about restraint and in discussing the development of common principles for the use of restraint in custodial sectors.<sup>83</sup> The use of segregation and restraint for custodial or punitive purposes in non-healthcare sectors creates difficulties in establishing common standards for restraint and segregation across all places of detention. However such common standards might "set a floor on which to build acceptable standards for inpatient mental health care".<sup>84</sup>

CQC is also engaged with the Department of Health in considering what further action may be needed with respect to recording and monitoring of restraint by providers and in developing guidance on best practice around positive behaviour support in settings where the patient is known to staff, so that physical restraint is only ever used as a last resort and never to punish or humiliate (see Department of Health, *Transforming care: A national response to Winterbourne View Hospital*, December 2012).

## Ensuring that restraint is used as a last resort

In most treatment settings where patients are detained, restraint appears to be carried out with reasonable safety and propriety the majority of the time. CQC is aware that there are instances, where restraint is necessary, that are extremely difficult to manage and that even well-trained and conscientious staff may not always get everything right all the time.

But even where restraint practice is good, detaining authorities should keep all incidents

under review and seek to ensure that physical intervention is always the last resort. This means attending not only to how staff respond to aggressive behaviour or other situations that result in physical restraint, but also the root causes of such behaviour. It is important that the possibility of environmental triggers are considered (for example boredom and frustration), but also that restraint episodes result in a review of the patient's care plan as required by the Code of Practice.<sup>85</sup>

A number of MHA Commissioners and stakeholders have shared concerns about police being called to assist in de-escalation of incidents on inpatient wards, and whether this is an appropriate response to the management of disturbed behaviour in a hospital setting. CQC is therefore including a question about this issue in thematic work for 2013, to help understand the use of restrictive practices on inpatient wards. CQC will also work with strategic partners – particularly in the police service – to develop a better understanding of this issue in the coming year.

### The use of a Taser as a restraint on psychiatric wards

CQC is aware of two incidents where patients on a hospital ward were restrained by police officers using a Taser gun. CQC is also aware of two further examples of patients who were Tasered while being transferred in detention. Only the police are authorised to use Taser. In both the hospital ward cases the patients had become increasingly disturbed and hospital staff, being unable to deescalate or contain the incident themselves, had called the police to manage the situation.

- A patient had been admitted to an acute mental health ward in an increasingly distressed state, had smashed glass and furniture there and armed himself with a piece of broken wood. The ward staff felt unable to protect other patients and called the police. The police used a Taser to restrain him, after which medication was administered and his physical health monitored before his transfer to a more secure ward.

- On a visit in August 2011, several patients said that they did not always feel safe on their ward, as there had been recent incidents when very distressed patients had threatened others. In an incident in the week before CQC's visit, a patient had set fire to his pyjamas and had been restrained by police with the use of a Taser. The Commissioner was told that there was only one male staff on duty and patients did not feel confident that female staff could physically deal with such incidents.

In addition, a patient who was in seclusion in another hospital had a Taser pointed at him by a police officer who was attending to support staff in entering the room.

It is of great concern that a Taser was used within hospital premises in this way. It may be that the use of a Taser can never be ruled out in this context, but any incidence of its use should trigger a thorough consideration of whether the staffing of the hospital unit is adequate to maintain safety, both in terms of staff numbers and staff training.

### Mechanical restraint

CQC expressed concern at the use of mechanical restraints in hospitals in its first annual report, and suggested that some form of notification procedure might be needed to obtain a true picture of practice.<sup>86</sup> The examples of mechanical restraint that are probably in most common use in hospitals – such as bed rails or supportive chairs – are often not recognised as such, and are in use for a far wider group of patients than those who might be detained under the Mental Health Act.

It seems likely that mechanical restraint is used most often on forensic Mental Health Act detainees when they are being conveyed to hospital by the police, or being transported between hospitals or between hospital and the courts. In its first report CQC expressed concern about a patient being taken to a hospital appointment in handcuffs<sup>87</sup>, and are disappointed to note that this is still happening on occasion. In the following case, the hospital acknowledged that it was at fault when the



patient made a formal complaint, and stated that handcuffs should never have been used:

BB I had to attend A&E because of my deliberate self-harm. I felt that my dignity was totally taken away from me as they made me wear handcuffs to and from A&E and also whilst in A&E. Obviously this attracted attention to myself and made me feel like a criminal! What really took my dignity away was when I needed to use the toilet: not only did the staff come inside the toilet with me, they actually kept me in handcuffs which made me unable to wipe myself, and I had to bend over like a toddler and let the staff wipe my bum. I had no dignity whatsoever and was very embarrassed and made to feel very small. DD

The use of handcuffs without justification is likely to be a clear and actionable breach of a patient's human rights.

The rare use of mechanical restraint in the high security hospitals appears, by contrast, to be well considered and genuinely a last resort, as recommended by NICE guidelines.<sup>88</sup> In this period CQC has noted the use of a hand-restraining belt in one hospital. The belt was used to prevent repeated and life-threatening attempts of a patient to manually disembowel herself. The hospital ordered a corset type device that could allow the arm restraints to be removed while protecting the healing wounds. CQC was satisfied that the hospital was continually reviewing its practice and seeking the least restrictive way to provide care to the patient while preserving her life.

# 4. Care pathways

## Key findings

- CQC saw evidence that many Approved Mental Health Professionals are trying to find alternative care for people that avoids them having to be detained in hospital.
- Pressures on beds continued to put services and patients under stress, making it harder to provide appropriate care for people in times of crisis. In 2011/12, 93 wards (6% of all wards) visited had more patients than beds; a further 10% were at full capacity.
- Patients are being affected by reductions in staff numbers. For example, MHA Commissioners raised concerns in 77 visits that a lack of staff prevented patients taking escorted leave.
- In some services MHA Commissioners saw excellent examples of patients benefitting from psychological therapies. But in others, services were too ready to rely on psychiatric medication as their response to patients' distress.
- Patients are benefitting from good discharge planning in a number of units – with considerable investment in time and effort being spent in identifying step down accommodation and suitable support arrangements. But an unacceptably high proportion – more than a third of care plans – still showed no evidence of discharge planning.

The management of pathways into and out of detention, with timely access to appropriate treatment, is fundamental to operating the Mental Health Act in a way that is consistent with the guiding principles of the Code of Practice. Multi-agency working and professional collaboration are key to promoting access to high quality care and treatment in the least restrictive environment – as envisioned by the national strategy on mental health.<sup>89</sup>

In England the Care Programme Approach (CPA) has been used since 1990 to support and co-ordinate effective mental health care for people with severe mental health problems – including all those subject to the Act. National guidance on the CPA describes an approach to integrated care pathways to coordinate care for people with complex needs. The Code of Practice makes reference to the CPA at a number of points in the context of guidance on care planning, treatment and support for people subject to the powers of the Act.

MHA Commissioners meet with many professionals who are clearly committed to this approach, and who seek to find the best pathways for individual patients within the existing service infrastructure. However, both professionals and patients have raised concerns and frustrations over available care pathways with MHA Commissioners on their visits, which are explored in this chapter.

“ I’m technically a prisoner. I’m on section 47/49. I’ve been sectioned four or five times. They put me back in prison, where it’s ram-packed with people who are really ill – and I’m soon back out again on section ”

#### Service user detained under section 47/49

### Approved Mental Health Professionals

Approved Mental Health Professionals (AMHPs) are responsible for co-ordinating assessments for detention under the Act, and are usually the applicant for such detention.\* They are also responsible for making reports on patients’ social circumstances to inform care, treatment and discharge planning.

In some local authorities the number of AMHPs is falling, although there is no reduction in either casework or statutory workload. Indeed, the latter has increased over the last five years and now includes not only assessments for possible detention under the Act, but also agreeing to and renewing community treatment orders. AMHPs may also be trained as best interest assessors under the Deprivation of Liberty Safeguards.

CQC heard of one AMHP who, in addition to carrying out statutory duties, had a caseload of 70 people. Many service users will also now be subject to work capability assessments to enable them to claim or continue claiming benefits, and social workers have reported to CQC and in the press that this has increased their workload.<sup>90</sup> This is a service under severe pressure.

AMHPs may only make an application for admission under the Act if they are satisfied that

detention in hospital is the most appropriate way of providing the care and medical treatment that the patient needs, and must make an independent decision from a social perspective about whether there are alternatives to such detention.<sup>91</sup> CQC has seen good evidence of AMHPs seeking alternatives to hospital admission, and in some cases AMHPs reported that a number of alternatives to admission under the Act – such as crisis houses or other staffed or supported accommodation – were both available and used before admission under the Act was considered.

However, in many of CQC’s meetings with AMHPs, they said that practical alternatives to admission could be improved. For example:

- In a meeting in March 2012, AMHPs from a rural area of England said that there was a lack of alternative accommodation that might provide a realistic alternative to admission, such as crisis houses.
- A month earlier AMHPs from a large city area told CQC that respite accommodation was not always available. This was because of a difference in the assessment of risk between the professionals involved and the third party organisation providing the respite care.

\* A patient’s ‘nearest relative’ may also be the applicant for their detention under the Act, but this seems to rarely occur.

- In one authority, AMHPs felt that crisis and home treatment teams were underperforming in their role to provide practical support as alternatives to hospital admission. This was seen as due to the funding cuts to such teams. AMHPs from this authority suggested that there was significant pressure on beds and noted a high use of the police holding powers under section 136, particularly out of hours.
- AMHPs in another authority said that their hospitals seemed to have an 'aversion' to voluntary patients, and that there were significant difficulties finding a bed for voluntary patients which they felt as a pressure to use the Act. In other authorities, AMHPs also told CQC that they feel pressure to use detention under the Act as a means of ensuring access to a bed.

An individual for whom an application for detention is being made is not necessarily a higher clinical priority than another who is willing to accept voluntary admission, but when access to hospital beds is under pressure it is one way of indicating priority. This may be one factor behind the continuing high use of the Act.

In contrast, CQC has noted some innovative arrangements for access to services for ex-patients in England. At Harrison House (NAVIGO Community Interest Company), inpatient services allow ex-patients to 'pop-back' for coffee and a chat as an alternative to formal admission. Where such arrangements can be made (in this example it is facilitated by the integration of the crisis and inpatient teams), they may well help many service users to avoid a crisis in their mental health, and reduce admissions and the use of powers of compulsion.

CQC notes with interest the provision in the Mental Health (Wales) Measure 2010 that, from June 2012, requires secondary mental health services in Wales to enable people they have discharged to refer themselves directly back to the service if they believe their mental health is deteriorating significantly, without having to first go to their GP or elsewhere for a referral.<sup>92</sup> This is an unusual use of mental health law in that it aims to empower patients rather than services, and as such may well enable patients' to exercise

greater autonomy. Commissioners and providers of mental health services in England should consider lessons from this initiative.

## Identifying the responsible local authority to arrange assessment

With many patients placed out of their home area, either because they are in specialist services or because no local bed is available, there can be disputes between local authorities over who is responsible for assessments under the Act relating to initial detention or aftercare. In some cases there is resistance from local authorities, who are concerned that arranging an assessment will make them liable for funding aftercare if the patient is admitted under section 3 of the Act.

The rules in relation to this are not always well understood. The Mental Health Act 1983, as amended in 2007, says that if a local authority has reason to think that an application may be necessary for "a patient within their area", it has a duty to arrange for an AMHP to consider the case.<sup>93</sup> This includes residence in a care home or hospital<sup>94</sup>, but excludes residence as a detained patient.<sup>95</sup>

As such it should always be possible to identify as an objective fact which authority has the responsibility. However, CQC has been contacted in the year by some hospitals who have found it very difficult to get their local authority to arrange assessment of patients who had been transferred to them as voluntary patients, but who may now need formal detention. In one example in December 2011, CQC suggested that the hospital managers draw the dispute to the attention of both relevant directors of social services as a matter of urgency, so that the patient's needs could be assessed and addressed.

## Bed occupancy

CQC has raised concerns about occupancy levels in previous reports. The Royal College of Psychiatrists has said that bed occupancy rates are a main driver of inpatient care standards, and recommends an optimal bed occupancy rate of 85%.<sup>96</sup> NICE guidelines recognise that overcrowding leads to tension, frustration and overstretched staff in psychiatric inpatient units.<sup>97</sup>

Table 5 shows the breakdown of bed occupancy levels recorded by MHA Commissioners over the last two years. During 2011/12, around half of wards had an occupancy level of 90% or less. Six per cent of all wards (93 wards) were allocated more patients than they had beds, and a further 10% were at full capacity. Such occupancy levels can delay admissions, or put pressure on services to discharge patients or grant overnight leave earlier than might otherwise be advisable.

**TABLE 5**

Occupancy level of wards visited by MHA Commissioners, 2010/11 and 2011/12

Ward occupancy level	2010/11 (1,642 responses)	2011/12 (1,511 responses)
90% or less	50%	52%
91% – 99%	35%	32%
Exactly 100%	9%	10%
101% – 109%	4%	3%
110% – 120%	1%	1%
Over 120%	1%	2%

Source: CQC

Over-occupancy can create a number of problems. In one London acute ward, 27 patients were allocated to the 19 beds. This was being managed by the ‘sleeping out’ of patients on another, empty ward. But one patient said that it meant that there was nowhere private to rest during the day, and that communal space on the ward was overcrowded. Another patient

expressed concern about his safety, and a third was worried about the safety of his possessions. CQC had been reassured, when raising the issue of over-occupancy on previous visits, that recovery houses were to be opened to ease the overcrowding problem, but these had not yet opened when CQC visited. CQC asked the trust to say how these problems would be addressed, and is continuing to monitor systemic changes.

In various parts of the country CQC heard that patients may be discharged from hospital too early, or without sufficient support in place, as part of the management of bed occupancy. At a meeting with AMHPs in South West England in March 2012, CQC was told that this was causing an increase in assessments for detention under the Act, because patients who had recently been discharged were assessed and detained again with increasing frequency.

On a visit in South East England in September 2011, CQC found 29 patients allocated to a 22-bed acute ward. CQC was told that, following restructuring, community services were not ‘taking up’ patients immediately on discharge from hospital, and patients were relapsing and being readmitted due to a lack of community support. Hospital staff had tried to address this by using leave under section 17, rather than discharge from hospital, until such time as community services could form a working relationship with patients. This is an example of failures in discharge planning and means that the period for which patients are subject to the Act is being extended beyond that which might be necessary if local arrangements work better.

BB To be fair to psychiatrists, beds are closing, CPNs are disappearing, the pressure on doctors’ resources is such that their role is changing. They are under such pressure to keep people out of hospital. How do they do it? – Vacate, medicate. DD

**Service user subject to a CTO**

In its last report CQC repeated its concerns over delays in admission of detained patients due to the unavailability of beds.<sup>98</sup> AMHPs from the West Midlands told CQC in February 2012 of the difficulties in identifying available beds, including occasions when people arrested under criminal justice legislation had been left for long periods in police detention after a Mental Health Act assessment had been requested (leaving the police with a dilemma whether to keep the person in custody beyond the legal time-frame allowed to them, or release them back into the community).

In May 2012 the European Court of Human Rights ruled on a similar situation, finding that the detention of a mentally ill man in police custody for over three days before his removal to hospital amounted to degrading treatment.<sup>99</sup>

At the February meeting, AMHPs also told CQC of situations where they had recognised a need for detention under the Act following an assessment, but not made an application because a lack of beds. CQC sampled 14 assessment reports from the area and found that two of these recorded that no application had been made for detention in hospital because no bed could be located.

Carers, service users and AMHPs report that 'breaking point' has to be reached for admission to be agreed. AMHPs and carers report that it is difficult to obtain a bed for a service user who agrees to enter hospital informally, as detained patients appear to have priority. Some service users and carers feel that the only way a service user can be admitted is to take an overdose. In one case, there was criticism of the 48 hour response time offered by the crisis team. Carers feel that help is not made available at an early enough stage, leading to avoidable detentions.

### February 2012

CQC asked services to consider how they monitored and learned from admission delays. The local authority, which previously analysed data from AMHP reports locally, agreed to share its findings with other agencies to help identify themes and take joint action as required.

CQC has previously recorded delays in the Manchester area which had resulted in a lapsed application for detention, indicating severe delays (applications are valid for 14 days after their last supporting medical examination).<sup>100</sup> In December 2011 the Coroner for Manchester City District, in reporting on the circumstances of the death of a detained patient, Feisal King, in July 2010, noted that:

"It was acknowledged by all concerned that the lack of a suitable bed for a patient deemed to be suffering from mental disorder and whom should be detained for assessment and/or treatment is a serious matter. Tragically, Feisal was in this position not once but several times."<sup>101</sup>

The Coroner noted and endorsed steps taken by the Manchester Mental Health and Social Care Trust to minimise the risk of a similar event occurring, but suggested that they should be kept under careful review. CQC has continued to monitor the position carefully and discuss it with the trust. The trust has audited lapsed admissions and shown some improvement in reducing them.

## Transport problems

The Code of Practice states that there must be clear protocols for transporting patients between the various agencies involved, and AMHPs must not be left to negotiate arrangements with transport providers on an ad hoc basis.<sup>102</sup>

AMHPs have raised concerns in some areas about securing police or ambulance attendance at assessments, or attendance once a decision to detain a patient had been made:

A number of examples were given of AMHPs being left in service users' homes without any clear time when the ambulance would arrive. One AMHP describe waiting over two hours in someone's home in the week before our meeting. Another example was given where an armed response unit was required, but took two days for the Local Authority and the police to agree and for the assessment to take place. Throughout these negotiations the AMHPs



were concerned for the safety of the family of the service user.

## February 2012

In the above example, the mental health liaison group had addressed the problems and were agreeing response times to try to avoid future problems. CQC noted the commitment of both ambulance and police services to address the issues, and observed that the root of the problems was partly difficulties in communicating levels of risk between organisations in terms that are mutually understood.

The same authority sometimes used a private ambulance provider to transport patients. AMHPs said that getting the funding to do this could be difficult, and that they sometimes had to 'go through' several service commissioners before the service was agreed. It is vital that such bureaucracy does not cause delays that may endanger patients or others, and as such clear funding protocols should be in place.

## Conveyance to hospital under the Mental Capacity Act

In recent years CQC has noted with some concern that police officers have, on occasion, relied on the broad powers of the Mental Capacity Act (MCA) for authority to convey a patient to hospital-based places of safety.\* Some idea of the scale of this practice was given by one London NHS trust in a statement to the court in a legal challenge against this practice, which said that 24 people were brought to the trust's places of safety under section 5 of the MCA between December 2009 and December 2010, compared with 714 people brought in under section 136 of the Mental Health Act. Of the 24 patients brought in under the MCA, nine were then detained under sections 2 or 3 of the Mental Health Act.<sup>103</sup>

In the case before the court, the police were concerned that a person whom they had

encountered at her private residence was mentally disordered and should be removed to a place of safety. They could not use the powers provided to police officers under section 135 of the Mental Health Act, because they did not have a warrant and were not accompanied by an AMHP or a registered medical practitioner, as is required under that section. They therefore decided that they could rely on MCA powers to take the person to hospital, where she was kept in a place of safety for 13 hours before being detained formally under section 2 of the Mental Health Act.

The trust's statement demonstrates its unease at this practice:

"This case has highlighted the difficulties faced by staff when patients are brought to places of safety under the Mental Capacity Act. When a patient is admitted under section 135 or 136 of the Mental Health Act, there is a clear authority ... to hold the patient and if necessary deprive them of their liberty. However, when a patient is brought to hospital under the Mental Capacity Act, we are conscious that staff should not deprive the person of his or her liberty whilst at the same time trying to manage their mental health needs, the manifestations of which are usually acute, psychotic or manic and which make them a risk to themselves and/or others."

The court confirmed that the police were wrong to assume authority under the MCA to convey the patient to the place of safety, and that as a result she was unlawfully detained there for the 13-hour period.

However, the example illustrates the difficulties faced by the police when attending an individual in a private residence whom they believe to be suffering from a mental disorder and to be in immediate need of care or control. It underlines the importance of jointly agreed local policies on the use of sections 135 and 136. As the Code of Practice says: "Responsibilities should be allocated to those who are best placed to discharge them, bearing in mind the different purposes for which health and social services and the police service exist."<sup>104</sup> This is a needs assessment and service organisation issue for commissioners and providers of local health and social care services.

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\* The Mental Capacity Act 2005 provides statutory protection against liability for certain acts done in connection with the care or treatment of a mentally incapacitated person (section 5), provided that these are in the best interests of that person (section 4).

## Appropriate treatment and countering medicalisation

The Mental Health Act as revised uses the term “appropriate” in some of the criteria for detention for treatment (whether under the civil power of section 3, court powers or powers of transfer from prison). For such detention, a patient must be suffering from mental disorder of a nature or degree that makes treatment in hospital “appropriate”, and “appropriate medical treatment” must be available there.

BB I believe that my life turned around when I became involved with the forensic services. In acute settings, there was never enough time to listen to the patient, to provide enough psychological support as there was always a high turnaround of patients. My problems, when I was discharged, were never resolved, so I ended up costing the NHS more by very frequently ending up in hospital, and eventually in prison. Unfortunately, it was only once I’d got so unwell that I’d committed a crime that I found somewhere where they were willing to take it slowly, to listen to me, to build up relationships with staff – previously I’d seen staff and doctors as the enemy. DD

### Service user detained under section 37/41

However, the Code of Practice explains that this does not mean that the patients must receive the most appropriate medical treatment that could ideally justify the use of the Act, nor must such treatment address every aspect of the person’s disorder.<sup>105</sup> As a legal threshold for the use of the Act, the appropriate treatment test is therefore very easily met, particularly as the Act defines “treatment” itself to include, for example, nursing and “specialist mental health habilitation, rehabilitation and care”.<sup>106</sup>


The regulatory framework under the Health and Social Care Act 2008 requires treating authorities to ensure that patients are “protected against the risks of receiving care or treatment that is inappropriate or unsafe”. This is to be done through individual assessment of patients’ needs and the delivery of care and treatment that reflects published research evidence and good practice guidance issued by professional and expert bodies.<sup>107</sup> Both the Health and Social Care Act regulations and the Code of Practice also require respect for and involvement of patients in drawing up care plans.<sup>108</sup>

As such, providing treatment under compulsion that has been planned or provided without a patient’s involvement and is inappropriate for the patient’s specific needs and wishes raises regulatory (and ultimately ethical) issues.

CQC has found that some commissioning pathways lead to bureaucracy and delay in moving patients to the most appropriate services. In one example, CQC found that if patients on a particular acute ward required transfer to a psychiatric intensive care unit, three NHS trusts were involved in the assessment and transfer process. CQC raised this with all commissioning bodies involved and suggested that the process be simplified.

The use of the Act’s powers of compulsion should provide an opportunity for a thorough multi-disciplinary review of any previous care provided to the patient, with a view to developing a personalised and holistic treatment plan. Such a plan may well involve the use of medication or other medical interventions, but patients should be able to expect their plans to extend beyond a narrowly ‘medical’ framework.

BB I get a lot of support from different staff like OT, social work, doctor, psychologist, advocate as well as medication. I also get support from my primary nurse. It is helpful and I wouldn’t be where I am now if I didn’t get the support. Medication is just part of your recovery and support is the

other part. In the past I've seen people on forensic wards just treated with medication – sitting around with nothing to do, sleeping all day – but now they've brought out my shared pathway, when you're having your MDT meeting you're a more valued member of the MDT; you've got more of a voice. Things have changed for the better. 

**Shaun, service user detained under section 47/49**


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Not all patients' experiences have changed for the better. The following visit found a unit with no activities of any kind available for patients, partly due to delays in appointing an occupational therapist:

Patient 7 told the Commissioner that although they have plenty of activity and outings with section 17 leave, they have no programme of events on the unit. Having attempted to reduce smoking in the past placement he is now smoking twice as much: the patient attributes this to boredom and having nothing to do. In the past in other hospitals, the patient has been involved in many practical projects and would like to have a project to engage in as he expects to remain here for the foreseeable future. There is nothing in the care plan which addresses this serious omission from this patient's life.

**October 2011**

Some service users perceive the help offered to them as being too limited, with an over-reliance on medication:

 Turnover of patients leads to reliance on medication as the only intervention – they don't address quality of life on meds, reviews are a box-ticking exercise. If your mental state is stable, that's all they care about. I'm involved in a drop-in centre, offering peer support,

and some of our people are having a terrible time. One of us is taking depot medication – it was the only way he could get out of hospital – and he can't function, he's got no emotions. Another man – only 42 years old – has just had a heart attack, having gained a lot of weight. A 23 year old, on Clozapine since he was 18, has just been rushed into hospital with a massive blockage of the bowel, and now he's had a blood clot in his leg. 

**Service user subject to a CTO**

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In theory, the 2007 amendments to the Act expanded the number of professional groups who could, through training, become eligible to take up decision-making roles as Approved and Responsible Clinicians. This was underpinned by a policy aim, outlined in the 'new ways of working' initiatives<sup>109</sup>, to decentralise power and responsibility from the consultant psychiatrist and share it among the wider care team. Some legal commentators have suggested that the change could facilitate a complete re-evaluation of the medical model and a shift away from the domination of the medical profession towards a multi-professional, community-based model, which more accurately reflects contemporary psychiatric care.<sup>110</sup>

Four years on from implementation of these changes, there is little evidence of a broadening professional base identified as approved or responsible clinicians and, although CQC still sees some examples of good multidisciplinary team work in supporting patients, more progress could be made to ensure that patients' experiences of mental health interventions extend beyond receiving medication.

## Access to psychological therapies

Psychological therapies are an integral part of the recovery process, and wards should provide access to the range of psychological interventions that NICE guidelines stipulate for the acute illness phase of psychosis and other diagnoses.<sup>111</sup> These guidelines recommend at least one psychological intervention per week for inpatients.

The Code of Practice sets an expectation that psychological therapies should be considered as a routine treatment option at all stages of patients' treatment under the Act, and says that they are an important part of modern and holistic mental healthcare.<sup>112</sup> Access to at least one session of psychological therapy per week is also one of the 10 standards for inpatient wards suggested by the Royal College of Psychiatrists.

CQC has seen evidence of excellent psychology input to detained patients' care, clearly demonstrating the principles of respect and participation, and in general patients are keen to access psychological therapy. However, in some hospitals access to these services is problematic. Problems were noted by MHA Commissioners in 51 separate visits to wards during the year.

Psychology at this hospital seems very stretched. On this ward the interest of patients in receiving psychological therapy is generally quite high and the psychologist prioritises his time to meet this the best he can. This becomes increasingly difficult as the proportion of inpatients who are very ill, and who need individual therapy as they are too unwell to be in a group, has risen over the years. One psychologist, who has community responsibilities as well, is insufficient to provide an adequate psychology service across the inpatient acute adult services for this trust.

**May 2011**

Patients complain that they have to wait for up to six months to start a psychology course which is the main reason for their admission to the unit. This results in patients feeling that they are not making progress.

**June 2011**

In the above example, CQC required the hospital to review all cases where patients had been waiting for psychology courses and report back where patients had to wait for more than two months to start a course, with reasons for the delay. CQC suggested that the hospital considered modular courses.

In some cases, detention in hospital does not appear to be a gateway to psychological help. This can give the impression of inpatient services as over-reliant on psychiatric medication as a response to patients' distress.

The Commissioner was informed that few people have one to one psychology at present and those that do generally had therapy prior to admission anyway. The Commissioner noted that three out of four patients able to articulate on this subject said that they wanted psychology – this was unprompted by the Commissioner but in response to questions about activities and medication.

**November 2011**

In early 2012 CQC was in discussion with a trust where it had found inadequate access to psychological therapy for patients in a rehabilitation unit. It appeared that those patients who were already engaged with psychological therapies on admission to the unit could continue with it, but the only option for other patients was to access psychological help privately. CQC was extremely concerned at the provision of psychological therapy across the trust's specialist and secure services. The trust acknowledged the problem and informed CQC of a service redesign, but CQC continues to monitor this situation.

“ If you are going to restrict patients, care needs to be of a high quality and, to put it simply, the care component of detention leaves a lot to be desired. Everyone, not just in forensics, needs to have access to psychology – not simply added to a waiting list. Years ago I could have done with my emotional (not just medical) needs being met, but it was only when I entered the forensic unit that I had consistent psychological help. ”

Service user on a forensic ward for women

### The Royal College of Psychiatrists' 10 key standards checklist

1. Bed occupancy of 85% or less
2. Ward size: 18 maximum
3. Environment offers gender specific bedrooms and toilet facilities, and direct access to external space and a quiet room
4. Daily therapeutic activities
5. Positive risk management policy
6. Information sharing on diagnosis and treatment to inform the care pathway
7. Linking with external community for housing, faith communities, employment, voluntary services, etc.
8. Access to at least one psychological intervention a week
9. Daily one-on-one contact
10. Cultural sensitivity: staff trained in cultural awareness with access to interpreters

Royal College of Psychiatrists, *Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental healthcare*, 2011, Occasional Paper OP79

MHA Commissioners were concerned at the level of psychological intervention and nursing contact with patients on a visit to a women's service in November 2011. The ward had a policy, aimed at not giving positive reinforcement to self-harming behaviour, of providing the women with attention and support when they were not self-harming rather than when they were.

However, from their observations of the ward in operation and discussions with patients, the MHA Commissioners questioned whether the ward had any coherent strategy for treating the challenging group of patients on the ward, beyond ignoring the immediate practice of self-harm. Patients reported that staff were often too busy to talk with before an episode of self-harm,



and there was no therapeutic group activity on the ward to discuss issues of self-harm.

CQC required the hospital to inform it of the steps it would take to ensure an appropriate therapeutic structure, to train, recruit and support staff of all disciplines, and to ensure that care was delivered to the highest possible standard testable against NICE guidelines for the management of self-harm. The hospital has subsequently evidenced some systemic change.

## Staffing

A requirement of registration under the Health and Social Care Act 2008 is to show there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use services at all times.<sup>113</sup> The Royal College of Psychiatrists' standards for inpatient wards for working age adults includes factors that indicate if staffing levels are adequate.<sup>114</sup> These include ongoing reviews of staffing numbers and skill mix, taking into account levels of observation on the ward; the need for staff to escort patients on leave; levels of therapeutic engagement; and the acuity of patients on the ward. CQC takes account of this guidance in monitoring how staff capacity impacts on the care and treatment of detained patients, with a specific focus on the Code's guiding principles.

MHA Commissioners raised concerns in 77 ward visits that staffing availability affected patients' ability to take escorted leave. In these cases staffing levels were restricting patients' contact with the world outside the hospital, limiting their ability to deal with day-to-day matters such as dealing with financial affairs and purchasing personal items, limiting therapeutic one-to-one time with staff and ultimately delaying their integration back into the community.

On a visit to a ward that was allocated a total of 32 patients, the majority of patients expressed concern regarding staffing levels. They noted that staff were very busy doing paperwork, that the ward felt chaotic at times and that there were not enough staff on the ward. Patients noted that this impacted on their ability to take

section 17 leave, go for allotted smoking breaks or have 1:1 sessions with named nurses.

### August 2011

The following is a report from a weekday visit to an acute ward:

There were 28 patients assigned to this ward at the time of the visit (10 detained and 18 informal, with one patient on eyesight observations). Five of these patients were on overnight leave. There were only four staff (two registered) on duty. A further patient arrived for admission to the last leave bed just before lunchtime. It is requested that the staffing establishment of this acute admission and assessment ward is urgently reviewed and serious consideration given to a substantial uplift in staff numbers in view of the type of ward, its function, layout and size.

### August 2011

The large ward sizes in the above examples exceeded the recommendation of the Royal College of Psychiatrists that general adult wards should not have more than 18 beds.<sup>115</sup> The College says that larger wards can seem institutional; contribute to patients feeling less safe; and make it more difficult to build therapeutic relationships and tailor care to individual patients' needs.<sup>116</sup> However, services may perceive economies of scale in larger wards – including in relation to the staffing quotas across hospitals. In this way staffing cutbacks may hinder the safety and quality of hospital care.

On a visit to a learning disability rehabilitation ward, taking place on a Saturday, CQC found only two staff covering the ward. This appeared to be the normal weekend ward staffing (during the weekday service facilitators and managers add to the staffing complement). Although the ward only had six beds, CQC learned from patients, staff and by observation that this was not a safe level. As two staff could not safely restrain a patient, incidents were usually dealt with by a member of staff being called from another ward (similar practices are often used for night staffing



“ In the wards that I visit I see a number of patients who would stand more chance in the community if they had access to good accommodation and appropriate levels of support ”

MHA Commissioner, SW England, July 2012

of other hospitals). However, this would leave other wards with only one staff member while staff were assisting an incident. CQC learned of two incidents that gave it great concern:

- In the first, the ward being visiting was left with a single nurse as the other attended an incident on another ward, but then two patients on the first ward started an altercation which she was unable to manage alone. She was able to call for and receive help but the dangers of such situations are evident.
- In the second incident, both members of staff left the ward to help with an incident, and were replaced by an injured nurse who had been attacked by a patient on another ward. The injured nurse collapsed in the nursing office. Patients could not access the office to either help him or raise the alarm as the door had locked behind him. A patient on the ward told CQC that this was not the only time that patients were left without nursing cover and asked if he could have a panic alarm as he did not feel safe on such occasions.

The trust has provided CQC with some assurances in response to its observations over these incidents, but CQC continues to monitor the situation carefully.

CQC has seen other reductions in staffing and services available to hospital wards that could have a negative impact on the care pathways of detained patients:

- On a visit in July 2011, a ward manager and staff said that patients' activities had been reduced due to the loss of occupational therapy services. Nursing staff seemed to be

expected to fill the resulting gap. CQC was concerned to hear a staff nurse complain of the tedium involved in encouraging patients in food shopping, cooking and cleaning, and to hear from one patient that members of staff were impatient and shouted at him to motivate him. However, when CQC raised this the trust did respond with plans for ensuring patient access to regular, evidence-based therapeutic activities commensurate with their needs and aspirations for recovery, and that another occupational therapist had been recruited.

- In May 2011 staff on a child and adolescent unit said that their multi-disciplinary team had been diminished by the loss of the local authority social worker who had been based with them for many years: the funding for her post had been withdrawn. The parents of one detained patient told CQC how they were concerned that they would no longer get support from the social worker, whom they saw as their main link with the unit.

Staffing mix needs to be suitable to provide appropriate care and, when necessary, control. In chapter 1, we pointed to examples where staff had to rely on the police to exercise control on wards. CQC accepts that there will be some situations where this may be necessary, but has heard complaints from some police forces that they feel they are relied on too much by some hospitals, and have even been asked by some hospitals to carry out quasi-clinical roles in the management of patients:

According to seclusion documentation, the last patient to be secluded (in August 2011) was done so by police who strip searched him first, after forcibly removing him from the visiting room following threats of possession of a dangerous weapon and to harm staff.

#### September 2011

Hospitals should monitor their use of police time, with reasons, to inform their decisions on staff training and service organisation.

BB I found that hospital makes it hard for me to function in society. All I really know is life with support which is not what I want. I haven't spent long in the community since my first admission. It seems strange that hospitals like this exist because no-one needs this sort of help. People including myself predominantly don't want to be here. DD

**Service user detained under section 3 (age 26, detained off and on from age 17, currently in a low secure unit)**

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### Moving on from hospital

The question of whether treatment under the Act can be considered "appropriate" depends significantly on the alternatives. The fewer the facilities and support available in the community, the more likely it is that continued detention (or indeed an initial decision to detain) will be seen by concerned professionals as the only therapeutic option.

The serious case review into Winterbourne View shows the necessity of continued vigilance against the creation of long-stay hospital beds through poor commissioning practice.<sup>117</sup> The dangers of this are not confined to the learning disability sector. Service commissioners should be wary of the development of 'rehabilitation' units, perhaps particularly those taking up forensic patients in the low secure sector, that takes place

outside any joint local needs assessment. They should ask searching questions about what the benefits would be for individual placements and about the hospital's record in turning patients' lives around.<sup>118</sup>

BB Some people have been in so long that they've lost interest – given up – they're no longer interested in getting out. Especially people moving from the High Security Hospitals to medium security; they seem to get stuck in medium security, whilst everyone they knew has moved on, it's really sad. I don't think living in a forensic unit is a decent quality of life for anyone – it's supposed to be a temporary thing. DD

**Shaun, service user detained under section 47/49**

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The transition from being a detained inpatient to the community can be a daunting and dangerous time for patients. Where patients have had relatively long admission or are moving on from the secure sector, this transition needs careful management:

BB When I moved into the community the first time I moved from somewhere that, although it was a medium secure unit, was homely and small enough to make the transition to a community house more feasible. Now that medium secure unit is gone and there is only the large and very clinical centre where there are 15 beds. DD

**Service user detained under section 37/41**

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It is important that planning for aftercare starts from admission as an inpatient, and that particular attention is given to aftercare plans when a patient is due to have a Tribunal or managers' hearing against their detention:

 My longest section was for 27 months and I applied for a Tribunal and won it, therefore I was discharged that day. I thought that I would be fine and that I would be able to manage myself but because it wasn't a planned discharge I hardly had any support put in place to help me during crisis periods or even to monitor my mental health. Obviously because I had been detained for such a long period I found being at home very stressful and soon reached crisis point again, leading to my current section 3. This time, my team are working to put a robust care package in place and I have had a lot of involvement in what care I think I will need. I am very hopeful this time as myself and my care team are putting a lot of effort into my longer-term care needs, rather than being discharged with not enough support in place. 

### **Service user detained under section 3**

CQC has seen good practice in discharge planning in some units, with considerable investment in time and effort to identify step down accommodation and suitable support arrangements. But in over 4,000 care plans examined in 2011/12, over a third (36%) showed no evidence of discharge planning (see figure 9 above). This was a slight improvement from 2010/11, but it constitutes a serious failing in detaining authorities' duties.

In some cases difficulties in accessing community support or services causes delays in patients' discharge from detention. On one visit CQC heard

that the most challenging aspect of discharging patients was the availability of suitable accommodation, and that this had caused several delays. In another, accommodation was available but needed to be prepared before it could be lived in:

**Patient 8 reported long delays in deep cleaning his house and requested information on how much longer he was likely to be in hospital for. The Mental Health Act Commissioner looked at the records and accepted that this issue appeared to be subject to inordinate delays and appeared to be a factor in delaying discharge.**

### **November 2011**

A study of discharge patterns from medium secure units in south London suggests that a lack of supported mental health hostel beds in the community delays the discharge of detained patients subject to restriction orders.<sup>119</sup> Given the cost of medium secure beds, this is an area where better commissioning practice may be able to reduce costs while improving services and seeking the least restrictive options for patients' treatment.

Delaying discharge past the point at which it is clinically necessary meets neither the expectations of the Code of Practice nor the duties under human rights legislation. Delayed discharges through poor planning or disputes over funding could give rise to legal challenge as a breach of Article 5 of the European Convention on Human Rights.\* They are also a poor use of expensive and pressurised inpatient services.

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\* In September 2012 the European Court on Human Rights held that detention on an indeterminate sentence of imprisonment for public protection must provide a 'real opportunity for rehabilitation' and that unreasonable delay in this could lead to arbitrary detention (*James, Wells, and Lee v the United Kingdom* (applications 25119/09, 57715/09 and 57877/09) ECHR 340 (18 September 2012)). The Government has announced its intention to appeal the finding.

## Personal health budgets

Personal health budgets aim to give people control over a proportion of the money that is spent on their health care (but excluding primary and emergency care). The recommended process for receiving a personal budget is that, after an assessment of needs, an individual is told how much money is available to them and draws up plans for using the budget in ways that are intended to benefit their health and wellbeing. Plans for using the budget are agreed with and signed off by the primary care trust, after assessment by a panel or board for possible clinical and other risks. The personal health budget money can be held and managed by a health professional; held by another third party on behalf of the patient; taken as a cash direct payment held by the patient; or as a combination of these.

Some patients subject to community treatment orders in the South West of England had a personal health budget. This appeared to be working well and CQC welcomes the Government's intention, subject to expert review of ongoing pilot schemes, to extend these more widely to people receiving NHS continuing healthcare by April 2014.<sup>120</sup> Currently direct payments can be used for social care services as part of section 117 aftercare (section 57 of Health and Social Care Act 2001).

Although there are some people for whom a personal budget may not be appropriate, there are some very encouraging signs emerging from research on personal health budgets. People given a budget because of mental health problems reported greater wellbeing, less stress, reduced use of emergency services and better management of relapses. Budgets have been used to purchase therapies, personal care, respite, equipment and self-management courses, and people said that they had not anticipated how good they would feel when they had control over how they managed their health.<sup>121</sup> Further research suggests that mental health service users appear "to respond particularly well to personal health budgets", and personal health budgets are cost-effective for people with mental health problems.<sup>122</sup>

The research showed that, for some people receiving health and social care payments (which could apply to people with section 117 aftercare or CTOs), there were problems with integration of the payments and disputes about what they could be spent on. It will be important for mental health patients that the implementation of personal health budgets is consistent with guidance on joint provision for long-term conditions and NHS continuing healthcare.

The Department of Health should ensure that guidance on joint health and social care personal budgets applies to people who use mental health services. It should also seek to extend personalisation of health budgets to all patients for whom they may be appropriate, including patients discharged from detention under the Mental Health Act, whether or not onto a CTO.

## Top-up fees for aftercare accommodation

The Draft Care and Support Bill 2012 proposes to extend the ability to charge top-up fees for residential accommodation provided to meet aftercare duties under section 117 of the Act. This will allow patients who have been discharged from detention in hospital for treatment to choose accommodation that would otherwise be outside the price-range of a local authority, and pay a top-up fee of the cost difference.

CQC welcomes this, but notes that it introduces for the first time an ability to charge for residential accommodation under section 117, albeit only on a top-up basis. CQC has indicated in response to the draft Bill that it will be important to ensure that authorities do not exploit this by setting an unreasonably low "usual cost of providing or arranging for the provision of accommodation", to make top-up charging the norm or make it difficult to access local accommodation without incurring extra charges.<sup>123</sup>

# 5. Consent to treatment

## Key findings

- Consent to treatment discussions (before the first administration of medication) improved in 2011/12 – 55% of records showed these, up from 46% in 2010/11. But this means that in almost half of cases there was no evidence that doctors had talked to patients about whether they consented to proposed treatment.
- There was better evidence of consent discussions after the first use of medication (72% of records). But still this means consent was not discussed in more than a quarter of cases.
- One patient in 10 (receiving medication for three months or more) was prescribed medication above the legally authorised care plan.
- In CQC's view, the assumption of a patient's capacity to consent to or refuse treatment should be backed up by a written record. More than a third of records did not show any evidence of a capacity assessment (42% on admission; 36% at the end of three months or the last administration of medication).
- Patients may be reluctant to say what they think about their treatment in public, particularly in a traditional ward round. CQC saw some good services that have developed private arrangements instead of ward rounds.

The Mental Health Act provides specific safeguards in relation to specific treatment. Treatment with medication for mental disorder may be given for an initial three months of a patient's detention on the authority of that patient's responsible clinician\*, but after that time:

- If the patient is capable of giving valid consent and does so, the responsible clinician must complete a certificate T2 stating this, or
- If the patient is incapable of giving consent, or is capable of giving consent but refuses to do so, a doctor appointed by CQC must consider certifying on Form T3 that treatment is nevertheless appropriate.<sup>124</sup>

Except in an emergency, certification is required for the treatment of a detained patient with electro-convulsive therapy (ECT) at any time: by the responsible clinician if the patient consents, and by a doctor appointed by CQC (a Second Opinion Appointed Doctor) if the patient is unable to consent.

## Unlawful administration of medication

The majority of patient records checked on CQC's visits show that medication for mental disorder is being administered with legal authority. But a significant number show potentially unlawful treatment. Having checked over 6,000 relevant records over the last two years, CQC has found one in 10 records where patients who have been receiving medication for three months or more while detained are prescribed medication above the legally authorised care plan (**FIGURE 20**).

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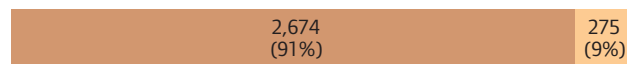
\* The three-month period starts from the first administration of medication for mental disorder to a detained patient: see Mental Health Act 1983 s.58(1)(b).

**FIGURE 20**

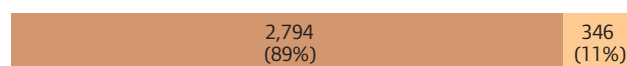
## Excess prescription of medication, 2010/11 and 2011/12

Where appropriate, was all psychotropic medication covered by Forms T2 and/or T3?

2011/12



2010/11



Source: CQC

The following examples show the sorts of problems usually identified:

Patient 9 had an extensive Form T3. However, on reviewing the patient's medicine chart the Mental Health Act Commissioners found that Olanzapine, a drug covered by section 58, was not authorised on that Form, and was being given daily. They further found that patient 9 did not consent to the medication being given.

### January 2012

It was a matter of serious concern that of three sets of detained patient notes scrutinised, in two cases patients were being prescribed medication for their mental disorder without the appropriate legal authorisation:

(a) From the expiry of the three month period, patient 10 has been administered medication without legal authority, including depot medication. On the day of the visit there was no evidence of either Form T2 or T3, and no evidence that the responsible clinician had assessed the patient's capacity or preparedness to consent.

(b) Patient 11 had also been receiving treatment for mental disorder whilst a detained patient for more than three months. Whilst he did have a valid T2 Form, this did not authorise the use of PRN Lorazepam prescribed for him.

### July 2011

In the above examples, the first patient's unlawful treatment in the absence of consent could amount to an assault in law. The second patient had certainly also been treated unlawfully. But the third had not at the time of the visit been treated with the drug prescribed outside of the legal authority (which was a drug prescribed to be given for anxiety on an 'as required' basis).

Where CQC believes that unlawful administration of medication may have occurred, it requires the hospital to inform the patient and support him or her to seek legal or other support, and audits other records to ensure that no other patients are being treated unlawfully or at risk of unlawful treatment.



“ I didn’t consent to treatment when I was suffering side effects but I was kept on the medication for three years. Now I do though because I know roughly how the hospital works. I felt totally ignored about medication until recently. Now they ask me how I am on the medication. I try to co-operate as much as I can. I think the staff listen. ”

Service user detained under section 3

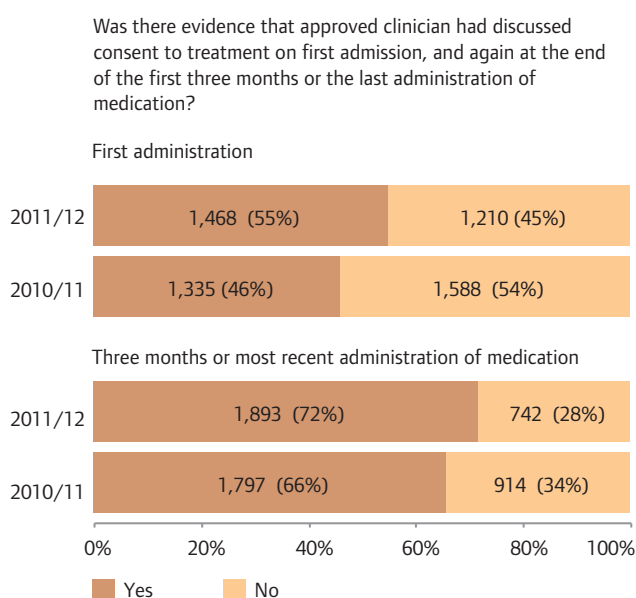
## Ascertaining patients’ consent and capacity to consent

Although the Act allows treatment without consent in certain circumstances, the Code of Practice requires that, wherever practicable, a patient’s consent should still be sought before treatment is given.<sup>125</sup> NICE guidance recommends that patients’ consent should be sought and decision-making capacity tested if it is in doubt before every treatment decision, whether or not a patient is detained under the Act.<sup>126</sup> MHA Commissioners check whether there is a record of such consent discussions in patients’ notes. There was an improvement between 2010/11 and 2011/12, but MHA Commissioners still found that a substantial proportion of services failed to meet the expectations of the Code (FIGURE 21). In a sample of over 2,500 records examined in 2011/12, 45% showed no evidence of consent to treatment discussions before the first administration of medication to a detained patient.

There is better evidence of consent discussions after this first use of medication, but still 28% of records in 2011/12 showed no evidence of a consent discussion at the end of the initial three months or at the most recent administration of medication.

FIGURE 21

Consent to treatment, 2010/11 and 2011/12



Source: CQC

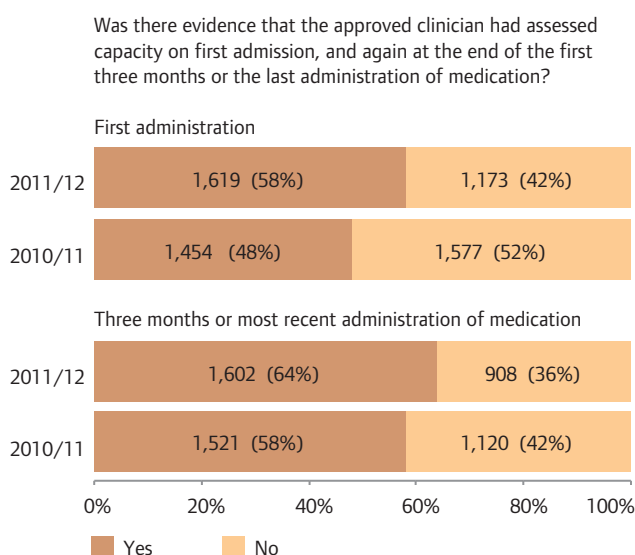
The Code of Practice requires clinicians to assess patients’ capacity to consent to or refuse treatment at the points where such consent is discussed, and record these assessments in the patients’ notes.<sup>127</sup> Some clinicians have questioned whether this conflicts with the first principle of the Mental Capacity Act, which states that people should be assumed to have capacity.<sup>128</sup> In CQC’s view, where a person is in the situation of requiring specialist inpatient

mental health care under the powers of the Act, the assumption of capacity should be backed up by an evidenced record. The Mental Capacity Act Code of Practice also states that professionals should never express an opinion about a person's capacity to make a decision without carrying out a proper examination and assessment.<sup>129</sup>

An incorrect assumption that a patient subject to powers of the Mental Health Act has capacity to agree to treatment may deprive that patient of the statutory safeguard of a second opinion. In CQC's examination of over 2,500 records in 2011/12, 42% did not indicate that a capacity assessment had taken place on admission, and 36% had no record of a capacity assessment at the end of the three-month period or at the last administration of medication (**FIGURE 22**).

**FIGURE 22**

#### Capacity assessments, 2010/11 and 2011/12



Source: CQC visits

The levels of non-compliance with the Code of Practice consent to treatment guidelines have been an ongoing problem in mental health services from the introduction of the safeguards in the Mental Health Act, and have been featured in every report to Parliament by the monitoring bodies for that Act. In particular, many previous reports have noted poor practice in operating the safeguards and questioned the reality of consent apparently given by patients.<sup>130</sup>

CQC continues to have concerns that not all services give sufficient regard to patients' wishes, or attention to their capacity to make decisions. In some cases what patients tell CQC in private interviews does not reflect their documented consent status in their treatment records. Such disparities in the recorded and actual views of patients suggest that patients have not had enough opportunity to engage with clinicians, as in the following example from a rehabilitation unit:

The Commissioner was concerned about the regularity and remoteness of medical input. This included significant periods of time without patients having any apparent contact with their responsible clinician; lack of capacity and consent recording ... and changes to treatment plans for one patient being e-mailed and used as a clinical record without any clinical record of an assessment.

#### November 2011

CQC does see examples of excellent practice in some hospitals:



The Mental Health Act Commissioner noted areas of good practice within the records [one of which was] the compliance with consent to treatment under section 58, notably the documentation of patients' capacity to consent and the record of meaningful discussion regarding consent recorded by the Responsible Clinician.

#### July 2011 Scott Clinic, Mersey Care NHS Trust

Mental Health Act Administrators can play an important role in improving or maintaining standards of consent to treatment practice. A number of trusts and independent hospitals' administrators have created forms to record patients' capacity and consent, and have been proactive in ensuring that clinicians comply with them. These forms can be a helpful way to ensure that clinicians undertake capacity tests using the criteria established under the Mental Capacity Act, and record the reasons for their determination of patients' capacity.

Our concerns about the reality of consent, in patients who are deemed to be consenting, can also be about the way in which those conversations take place. Patients may sometimes feel inhibited in giving their views, particularly in a traditional ward round where a number of professionals go from patient to patient. Some services have developed more personalised arrangements, with individual appointments to see a doctor, nurse or pharmacist in private. Some use pharmacists quite extensively to make sure that patients understand the medication they are on, and as a source of additional advice.

If detention and compulsory treatment under the Mental Health Act is going to be an intervention leading to recovery, it must seek to restore patients' autonomy. As such, a core function of inpatient care is to establish trust and a therapeutic relationship between the patient and clinical staff:

 In the beginning I had a great resistance to being put on a depot injection and to begin with I fought physically against it. For a time I then reluctantly went along with it but still felt that I would stop taking it if I had the opportunity. In the end I learned to trust staff and doctors and learned to accept that I was finally on the right medication and understood that medications do play a part in my recovery. So despite years and years of having a depot forced on me, I now realise that even though it's not a pleasant experience, it is a valuable tool in keeping me well. 

**Service user detained under section 37/41**

CQC suggests in chapter 2 above that advance statements of treatment preference can play an important role in building the therapeutic relationship and empowering patients to influence their present and future care.

Commissioners and providers of mental health services should ensure that clinical staff receive appropriate training on good practice requirements in assessing and recording patients' capacity and consent status, including ongoing discussion with patients in one-to-one settings. This should include the promotion of advance statements of treatment preference wherever practicable. Provider boards should monitor compliance with this aspect of the Code of Practice.

## High dose medication

The Royal College of Psychiatrists has issued a statement on high-dose medication, which CQC uses in its monitoring of the Act.<sup>131</sup> CQC looks to ensure that clinical teams who are involved in the care of patients receiving high-dose medication are aware of the guidance and take it into account in practice. The guidance states that high-dose medication should only be used after other treatments have been tried, and after an individual risk-benefit assessment in consultation with the patient, who should be offered the support of an advocate. Careful health monitoring needs to take place where patients are receiving high-dose antipsychotic medication.

On a visit in November 2011 a MHA Commissioner met with two patients who, although they were receiving high dose medication that appeared to be appropriately monitored, said that they were unsure about the side effects of the medication, and wanted someone to explain the effects and side effects of their treatment regime. The trust provided a positive response which is highlighted here as a good practice example:

The medical and nursing teams regularly meet individual patients to discuss medication and side effects, particularly upon changes to medication and at care plan evaluations. Additionally group and individual sessions have

been offered by our pharmacist and our physical health leads. However, upon review, we agree that documented discussions of medication and side effects are infrequent in the notes and we are grateful that this has been brought to our attention. As a consequence we have added to our nursing ward round summaries a specific heading: “patient comments on medication and side effects” to be filled in fortnightly by the patient and their primary nurse prior to the multidisciplinary team meetings. Additionally each patient will have a Glasgow Antipsychotic Side-effect Scale completed at three month intervals.

**East London Foundation NHS Trust, November 2011**

## Self-management of medication

Wherever practicable, patients should be given an opportunity to manage their own medication before discharge from hospital, so that this step towards recovery takes place in a supervised and supportive environment. Star Wards and Wardipedia provide resources on graduated self-medication.<sup>132</sup>

BB For every medication there is a side effect. I’d love to see side effects taken more seriously than they are at the moment. It’s like, as long as your mental state is good that’s all that matters. DD

### Service user detained under section 47/49

CQC has seen examples where patients moving to conditions nominally of lesser security in a new hospital or ward find new restrictions placed on them. In the following example, this related to self-medication:

The Commissioner heard concerns from staff and the Responsible Clinician that patients are not currently afforded the opportunity to self-medicate. For some patients this is a regressive step in terms of their rehabilitation because they did self-medicate on their previous ward.


Apparently there are practical issues: however, staff feel that self-medication provides the opportunity to test compliance with medication which is a major consideration in relation to both recovery and rehabilitation.

### **August 2011**

An important aspect of success in supporting patients’ self-medication appears to be providing personalised advice and support about medication and its side effects. Detained patients are entitled to information on the legal position regarding the consent to treatment provisions of the Act<sup>133</sup>, and those provisions require that patients have an opportunity to understand the nature, purpose and likely effects of treatment.<sup>134</sup>

Supporting patients to self-medicate, both in hospital and after discharge, may also involve learning about how to cope with side effects, having strategies to remember to take the right doses at the right times, what risks there might be in using complementary medicines, alcohol or other drugs, and having a space to discuss and air feelings about medication.<sup>135</sup> Some wards arrange for pharmacists to be available to patients for these more personalised aspects of medicine management.

BB Twenty-five years from now we’ll be looking back at medication use and saying “what the hell were we thinking – look at what we’ve done to these people”. They’re saying that now with the older antipsychotics – saying “how dangerous were those!” I got diabetes from olanzapine. The drug company was sued in the U.S. and had to pay out, but what’s become of that in prescribing practice? I ballooned, put on stones, was drinking all the time and always thirsty. I started losing the weight in prison – I had ketones, was really ill – but no-one noted it, they just thought I was on drugs. I’ve spoken to others as well who’ve got diabetes. You can’t help but feel bitter,

it's a serious life-threatening illness, it shortens your life. 

**Shaun, service user detained under section 47/49**

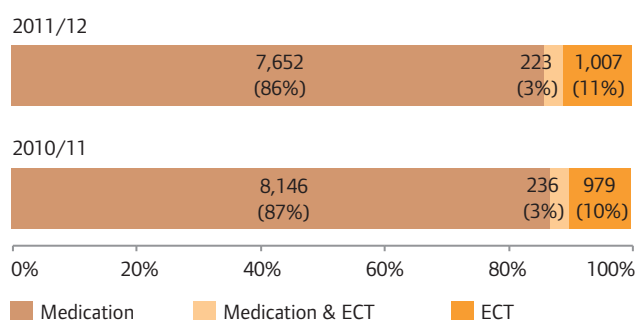
## Second Opinion Appointed Doctor visits

CQC has a statutory duty to appoint doctors to undertake second opinions under the Act to consider certifying that proposed treatment is appropriate and can be given in the absence of detained patients' consent. These Second Opinion Appointed Doctors (SOADs) act independently of CQC once appointed, and must reach their own view whether to certify proposed treatment as appropriate.

In 2011/12, SOADs completed 8,882 visits to detained patients, 479 fewer than in 2010/11 (**FIGURE 23**).



**FIGURE 23**

Completed second opinions by proposed treatment, detained patients only, 2010/11 and 2011/12



Source: CQC



Most second opinions consider treatment with medication: 7,875 (89%) of the visits to detained patients in 2011/12 were to consider medication, although this figure includes 223 (3% of all visits) where a patient was being considered for treatment with electroconvulsive therapy (ECT) as well as medication. There were 1,007 visits (11% of all visits) to consider ECT only in 2011/12. There was a similar pattern of treatment in 2010/11.

 I've seen a few SOADs in my time. I went into the room and they just go "you got any problem with your meds?" and that's it. It would be nice if they got to know you a bit, got to know your mental state. They tend to be very distant which makes you not want to tell them all the problems you're having with your medication. I've felt the line of questions being asked have a right or wrong answer and I'm scared to say the wrong thing. 

**Shaun, service user detained under section 47/49**

CQC continues to improve its arrangements for doctors to undertake statutory second opinions. For example, much administrative time was being wasted in chasing up requests for second opinions that did not provide enough detail. It therefore introduced an electronic form that must be completed fully before submission. Requests are now submitted through secure channels to CQC.

The clinician in charge of a patient's treatment is responsible for making the hospital's arrangements for a second opinion, such as ensuring that the proposed treatment plan is updated and that statutory consultees are available on the day of the visit. Most visits take place at a pre-arranged time. However, from its visits CQC knows that patients have raised concerns about the arrangements for SOAD visits:

 It would be nice to have notice that a SOAD is coming, and not just be pulled out of therapy or out of bed just to see them – so that you had time to think about things and any questions that you might have. 

**Service user subject to a CTO**



CQC expects services to give patients notice of a forthcoming SOAD visit wherever it is practicable, so that patients can make preparations, including arranging attendance of an Independent Mental Health Advocate if they wish. Exceptions should be made only where this notice might cause a patient or others significant distress or harm.

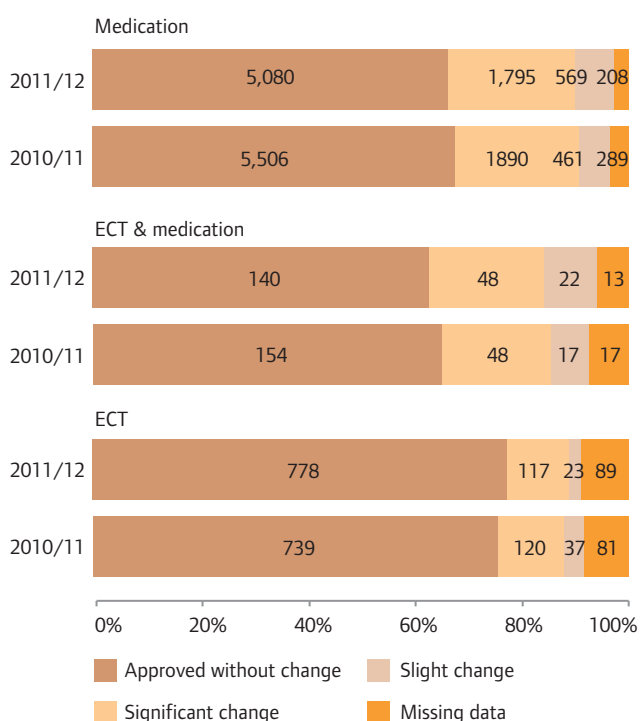
Further data on CQC's SOAD service relating to ECT treatment is in appendix B.

## The outcome of second opinions for detained patients

The outcome of all second opinions for detained patients in 2010/11 and 2011/12 is shown at figure 24.

**FIGURE 24**

Completed second opinions by outcome, detained patients only, 2010/11 and 2011/12



Source: CQC

SOADs submit a report on every individual second opinion undertaken, which shows whether they have endorsed the proposed treatment plan without change, or changed it to a slight or significant extent. Approximately 30% of SOAD visits to consider treatment with

medication (whether or not in combination with ECT) resulted in some change to the proposal. This is double the rate at which treatment plans involving only ECT were changed.\* There are a number of possible reasons for this. It may be that the declining rate of ECT referrals (see appendix B) means that patients for whom the treatment is proposed are less likely to be 'borderline' cases than those for whom the appropriateness of the intervention is in doubt. ECT referrals may also present SOADs with many more binary decisions – either the treatment is appropriate or not – whereas medication proposals are likely to involve several elements that may or may not be considered appropriate by the SOAD.

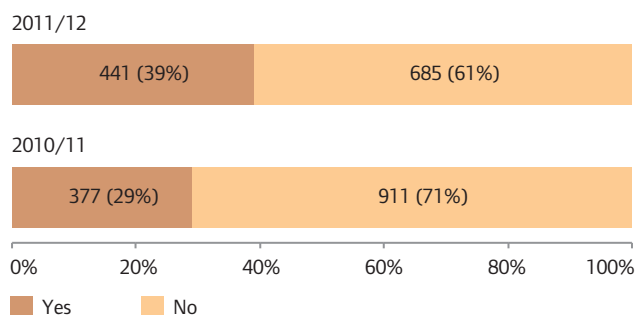
The Code of Practice requires the clinician in charge of treatment to inform a patient of the outcome of the second opinion and, unless either the SOAD or the clinician thinks this would cause serious harm to the patient or others, provide the patient with the SOAD's reasons for the decision.<sup>136</sup> The clinician in charge of treatment should document these actions.<sup>137</sup> While CQC has seen an improvement from 2010/11, the majority (61%) of patient notes examined did not record that this information was given to patients (FIGURE 25) and CQC will continue to focus on this aspect of clinical practice during its visits.

\* These measurements can only be approximate given the percentage of missing data on whether the outcome of the second opinion visit was a change to the proposed treatment. For ECT decisions, missing data accounts for between 8% and 9% of the dataset; for visits to consider only medication the missing data is no more than 3%.



**FIGURE 25**

Evidence that approved clinician explained result of SOAD visit, or reason why not appropriate to do so, 2010/11 and 2011/12



Source: CQC

## Consent to treatment and CTOs

In 2011/12 SOADs completed 3,239 visits to CTO patients, 440 fewer than in 2010/11. The outcome of visits by consent status is shown at figure 26.

In contrast to the position of detained patients, throughout 2010/11 and 2011/12 SOAD certification was required where a CTO patient was consenting to treatment. Over two-thirds of second opinion visits to CTO patients over the two years were to consider treatment plans to which patients were consenting.

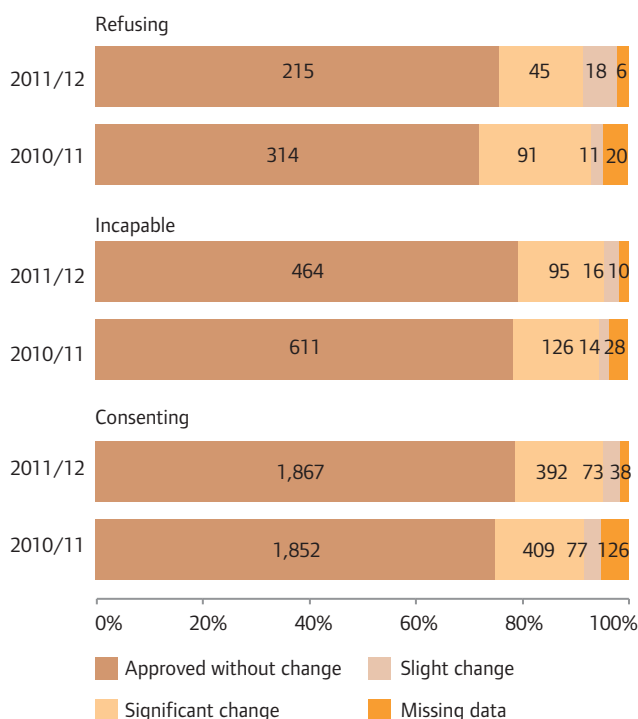
CQC discussed the requirement for SOAD certification of consenting CTO patients' treatment in its last report.<sup>138</sup> During 2011/12 CQC continued to find this group of patients hard to engage in the second opinion process, and some patients resented having to have a doctor certify treatment to which they consented<sup>139</sup>. Although one in five SOAD visits changed treatment plans for consenting CTO patients, the SOAD certification requirement for consenting CTO patients was difficult and costly to administer, and not mirrored by any such requirement for detained patients.

Changes to regulations effective from 1 June 2012 removed this requirement, so that the clinician in charge of a CTO patient's treatment now completes a new form CTO12 if the patient consents to treatment, and no SOAD involvement is required.<sup>140</sup>

CQC will continue to give close attention to consent to treatment issues in its monitoring of the use of the Act, and will expect hospital and community service managers to audit and ensure good care planning and consent to treatment practice in relation to this group of patients.

**FIGURE 26**

Outcome of SOAD visits to CTO patients, by patients' consent status



Source: CQC

## CTO patients who refuse treatment

In 2011/12, CQC arranged 284 visits to CTO patients who were deemed to have capacity to make a decision about their treatment, but who refused to give consent. Requests for such visits are made to CQC so that a SOAD can consider certifying on form CTO11 that:

- Certain treatment proposed for the patient while in the community is appropriate, even though such certification provides no authority to give the treatment where a patient refuses consent, and/or

- b) Certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital.

CQC has continued to accept requests to issue these certificates after the new regulations came into force in June 2012, but services should be aware that certificates given in these circumstances provide no legal authority to give treatment to patients in the community if they refuse it. Furthermore, after June 2012, a certificate issued in the circumstances described at a) above could not be used to fulfil the certification requirement if the patient subsequently consents to treatment: in these circumstances, the patient's doctor needs to complete form CTO12.

## Age and gender of CTO patients receiving second opinions

Figure 27 shows the age and gender of CTO patients for whom a second opinion was completed in 2010/11 and 2011/12.

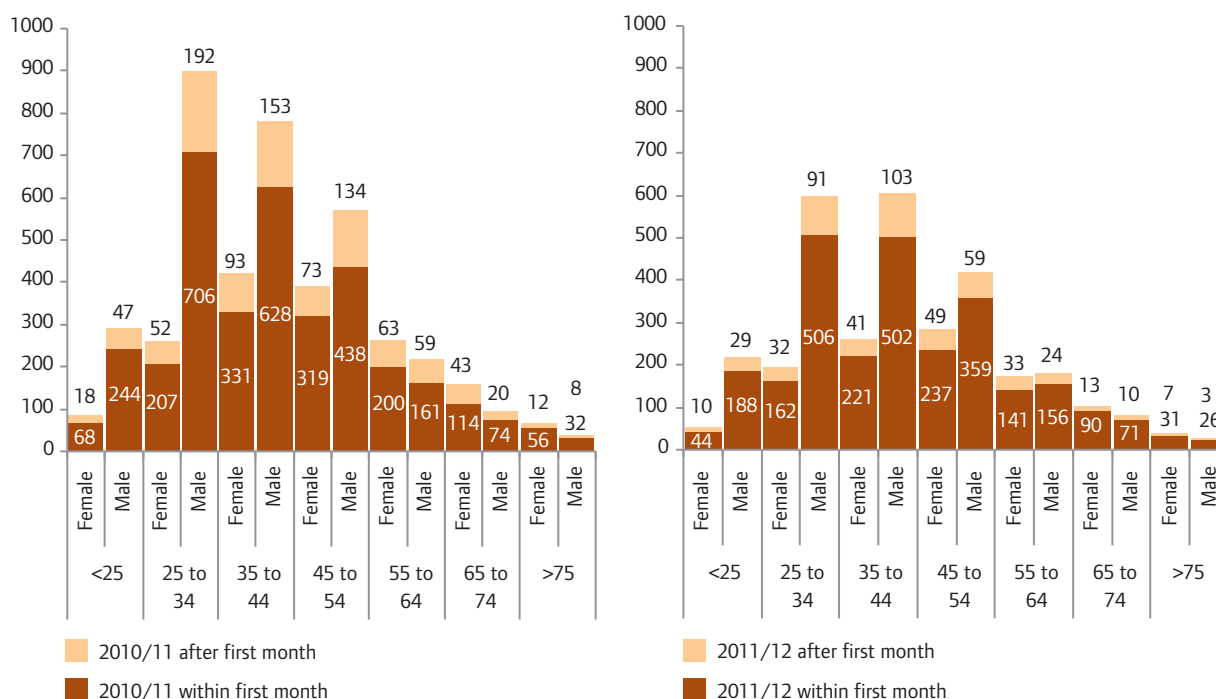
As all patients who became subject to CTO during 2010/11 and 2011/12 would have required a second opinion at some point, this data is therefore a proxy measurement of the age range of the CTO population. There are some limitations to this data. Some patients may have received more than one visit, although we can be quite confident that visits requested in the first month of patients' CTOs relate to different individuals. Visits requested after the first month of CTO could represent new CTO patients who were discharged from section 3 before the first three months of treatment under detention had expired, or could be repeat visits to existing CTO patients.\*

Men in the younger age bands are the most represented groups.

\* Before 1 June 2012, all new CTO patients would have required a second opinion either within the first month of CTO or at the end of the three-month period during which certification would not have been required had they remained detained in hospital, whichever was the later date. After 1 June 2012 the same rules apply to the need for certification of treatment under CTO, but certification of consenting patients does not require a SOAD.

**FIGURE 27**

### CTO second opinions by age and gender, 2010/11 and 2011/12



Source: CQC

# 6. Community treatment orders

## Key findings

- CTOs are used widely by some providers, and used little by others. In an analysis of NHS organisations, the lowest reported 'discharge rate' onto a CTO was 4.0%; the highest was 45.5%.
- There were also a number of NHS organisations – with considerable rates of detention under the Act – that provided nil returns for the use of CTOs.
- A number of patients are worried that it isn't clear when a CTO will have served its purpose – and therefore they do not know what they have to do to come off a CTO.

Community treatment orders (CTO) were introduced in November 2008. CTOs are a discharge option for patients detained in

hospital for treatment under the Act (whether by 'civil' admission under section 3 or, if they are unrestricted\* patients, by a court order or transfer from prison). Patients subject to CTO can have certain conditions imposed on them, such as where they live, but these conditions cannot compel treatment or authorise deprivation of liberty. A CTO patient can be recalled to hospital for a period of up to 72 hours in certain circumstances, and within that time the CTO can be revoked, reinstating the detention order that was in force before the CTO took effect.

In 2011/12 there were 4,220 uses of CTOs (TABLE 6). While this is the highest number so far, the data does not show a straight increase year on year. The average number of CTOs instigated in the first three full years of implementation was 4,054.

\* See the footnote on page 16

TABLE 6

Use of CTOs, 2008/09 to 2011/12

Use of CTO	2008/09 <sup>141</sup>	2009/10	2010/11	2011/12
From section 3	1,602	3,736	3,606	4,004
From section 37	56	121	152	180
From section 47	2	6	12	5
From other sections**	474	244	64	31
Total	2,134	4,107	3,834	4,220
Recalls	207	1,217	1,601	2,082
Revocations	143	779	1,118	1,469
Discharges	33	1,010	1,167	1,712

Source: Health and Social Care Information Centre, KP90

\*\* Including transitional powers operative in 2008/09 that patients subject to aftercare under supervision (s.25A), a community power abolished with the introduction of CTOs, could be transferred onto CTO provided they met CTO criteria.

The number of patients discharged onto CTOs from section 37 continued to rise. These relate to patients discharged from an unrestricted hospital order made by the courts following conviction of an offence under section 37.

## Ethnicity of CTO patients

In collaboration with the University of Nottingham, CQC has sponsored quantitative research into the relationship between ethnicity and CTOs.<sup>142</sup> Demographic data was collected on all CTO patients for whom a statutory second opinion (SOAD) visit was requested between 3 November 2008 and 15 August 2011. While this research cannot provide reasons for any relationship between ethnicity and CTOs, it does provide a preliminary statistical analysis that could inform further studies.

There are some limitations to the study: using anonymised proxy data from SOAD visits rather than individual patients means that a small number of patients would have been counted more than once if they had more than one SOAD visit during the period. CTOs that lasted less than a month were unlikely to be counted at all as the law only requires a SOAD visit after the first month of the power being in place.\* The data did not provide information on clinical variables such as diagnosis, past admissions and history of medication compliance, indicate socio-economic status, or compare the ethnicity of the population who could be put on a CTO with the ethnicity of those on CTOs. Further detailed research comparing these is needed to understand whether there is an increased likelihood of various ethnic groups being put on a CTO.

The breakdown of ethnic categories by general, inpatient and CTO population is shown in appendix A. This shows that people from the Black or Black British group made up 15.0% of the CTO population, compared with 2.9% of the general population and 9.7% of the inpatient population.

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\* Or the end of the initial three-month period triggered by the first administration of medication under detention, whichever is the later date.

The study split the data by gender and age group. Similar patterns emerge for both men and women across age groups, suggesting that the differences in ethnic composition are not accounted for by these factors. CQC continues to support this ongoing research, and looks forward to further findings. It has been suggested elsewhere that the use of CTOs may be magnifying an existing disproportionate use of compulsion in the treatment of black people.<sup>143</sup> As noted in chapter 1, the forthcoming publication of the AMEND study findings may throw further light on this issue.

## Variation in CTO use in the NHS

We looked at NHS organisations that initiated 10 or more CTOs in 2011/12, and calculated the number of CTOs initiated in each organisation as a percentage of the number of formal admissions under the Act for that organisation. This is a proxy measurement: not all discharges onto a CTO will have involved people admitted in that financial year, and not all admissions in the year would have been under section 3 and as such eligible for discharge onto CTO. The results ranged from the lowest 'discharge rate' onto CTO of 4.0% to the highest at 45.5% and shows potentially wide variation in the use of CTOs. In addition, a number of NHS organisations with considerable rates of detention under the Act provided nil returns for the use of CTO.

## Patients' experiences of CTOs

Some patients have told CQC that they are content to be on a CTO because it has provided them with the help they need to remain well in the community. Patients on a visit in July 2011 gave examples such as support from care co-ordinators and consultant psychiatrists, and knowledge of who to contact in an emergency. However, these are services that should be available to any patient discharged from detention under section 3 of the Act.

The experiences of some patients on CTOs also raise the question of whether some coercive powers might be used as a gateway to services, as has been observed in other jurisdictions.<sup>144</sup>

CQC still encounters CTO patients who are receiving little support from or interaction with clinical teams:

Patient 12 said that while the CTO was working relatively well for him he described poor interaction with community staff saying it was all about 'just going to get my meds'. He had requested seeing a male for 1:1 sessions on a weekly basis but this had not materialised. The patient described being on his own most of the time. In addition to this he had a noticeable tremor and said his Orphenadrine which normally helps this had been stopped and he didn't know why. There appears to be no care plan indicating what mental health care and treatment has been planned for this patient whilst on a CTO.

#### September 2011

Patients from another CTO visit had various problems with their medication. CQC was concerned that infrequent contact with clinical staff meant there was limited opportunity for discussion of such problems. One patient told CQC that he felt he was on too much medication, as he felt lethargic, was having problems with mobility and was sleeping for around 15 hours every day. Another patient also felt over-medicated and lethargic, and was concerned that she had been told her medication dosage would be likely to reduce after six months of CTO, which had now passed without any change being suggested. A third patient wanted to complain about his medication, but did not know how to do this or who to speak to.

The division of mental health services into 'functional teams' means that the responsibility for many patients passes, at the point of discharge onto CTO, from an inpatient psychiatrist to a community psychiatrist. The Code of Practice stresses the importance of liaison with the community clinician and team at an early stage where this model is used<sup>145</sup>, but this guidance is not always followed and CQC encountered some confusing transfers of responsibility:

It was unclear how and when responsibility was transferred from the inpatient responsible

clinician to the community responsible clinician. There seemed to be no clearly identified process for transferring responsible clinician duties from one doctor to another. Without a proper protocol in place for a handover to a community responsible clinician, delays can occur when an inpatient doctor disagrees with a community doctor about the CTO conditions or treatment regime. Some patient records indicated confusion as to who would manage patients' clinical care in the community. The Commissioner found statements like 'your responsible clinician will be Dr X' followed, two days later, by 'your responsible clinician will be Dr Y'. For one patient this happened three times. Several patients interviewed did not know the name of their responsible clinician.

#### 24783

This was an issue picked up by the Mental Health Alliance's survey of the use of CTOs in 2010.<sup>146</sup> This is disappointing given we are two years further into implementation of this provision. It merits further consideration as to the barriers to effective implementation.

### Procedure for initiating a CTO

In its first annual report CQC pointed out that, in contrast to the procedure for detention, there is no statutory limit of time that may pass between the two statements required on form CTO1 that the criteria for a CTO are met.<sup>147</sup> It pointed to examples where considerable time had elapsed between the doctor's initial statement that the criteria were met and the confirmation by the Approved Mental Health Professional (AMHP) that this was the case. This is still a concern.

In 2011/12, CQC noted a related area where the procedure for CTO appears to provide a weaker safeguard than that for detention. The form CTO1 is in three parts: in the first part, the patient's doctor certifies that the conditions for CTO are met; in the second part the AMHP certifies his or her agreement with this statement, and in the third part, the doctor signs and dates a statement making the CTO effective from a date that he or she specifies. In some cases CQC found that the patient's responsible



clinician completed, signed and dated both the first and third parts of the form, then passed it to an AMHP who subsequently completed the second part:

The responsible clinician had signed part 3 of the form on 24/01/2012, the day before the AMHP signed part 2 on 25/01/2012.

### March 2012

Although the matter has not been tested in the courts, this might render the CTO unlawful, as the Act requires that “the responsible clinician may not make a community order unless (a) in his opinion the relevant criteria are met and (b) an AMHP states in writing (i) that he agrees with that opinion; and (ii) that it is appropriate to make the order”.<sup>148</sup> In any case, it gives the impression that the doctor has treated the requirement for an AMHP’s agreement as a mere formality that can be assumed, and for this reason CQC regards it as inappropriate. Although the current edition of the Code of Practice assumes that the third part of form CTO1 will not be completed unless the AMHP has given written agreement that the CTO should be made, this point could be emphasised in the next revision of the Code.

Parts 1 and 3 of form CTO1 are to be completed by the patient’s responsible clinician.<sup>149</sup> CQC has noted, and been asked about, examples where there is a change of responsible clinician between the completion of the first part of the form, stating that the conditions for a CTO are met, and the second part exercising the power to make the order. In so far as the identity of the responsible clinician has changed in fact (which is determined by who is actually in charge of the patient’s care and treatment at the time), CQC can see no reason why this should be a problem for the lawfulness of the process.

AMHPs are required to take into account the patient’s wider social context when considering whether the conditions for a CTO are met. Ideally, the AMHP should have been given time and opportunity to meet with the patient, read case notes, and explore the patient’s social context by, for example, follow-up contact with family members or carers. The Code of Practice

reminds professionals that, even if the criteria for a CTO are met, this does not mean that the patient should be discharged onto a CTO. AMHPs should consider “relevant factors” of social context including “any support networks the patient may have, the potential impact on the rest of the patient’s family, and employment issues”.<sup>150</sup>

CQC would expect such considerations to be recorded in the patient’s notes, whether or not the AMHP agreed with the imposition of a CTO. In its first annual report, it pointed out that the Code of Practice is less exacting in its recommendations on this in relation to CTOs than it is in relation to detention.<sup>151</sup>

CQC has encountered some CTO cases where the lack of recorded reasoning by the AMHP has caused concern:

AMHP agreements to applications and extensions of CTO and agreements to conditions did not show clear reasoning for the use of such power:

Patient 13: AMHP records a CTO application interview but little explanation or rationale for the decision to agree or consideration of appropriateness of conditions. More information is given on explaining the CTO and rights to the person. No mention is made of the patient’s view of CTO.

Patient 14: Extension of CTO – nothing on record about AMHP’s rationale for continued use of CTO or application of conditions.

Patient 15: First extension of CTO – very brief reasoning given and rest of notes are concerned with AMHP explaining the CTO to the person. The record also states that the patient is not even aware of already being on a CTO; is well in the community and happy to take their medication, which potentially raises issues about meeting the criteria for CTO. Second extension of CTO – nothing on record apart from joint visit to see the person with CPN and consultant.

Patient 16: Application for CTO – AMHP record is of their attendance at CPA (same day) with view to application of CTO but then no reasons



or rationale given for agreeing to the CTO. The notes are primarily about informing the person of the completed CTO, conditions and rights.

**June 2011**

CQC discussed its concerns in the above example with the lead AMHPs for the area, and they agreed to address their practice.

CQC has found that professionals involved with patients subject to CTOs may not have access to any ongoing training about the legal and practice framework around CTOs. In particular, given that care co-ordinators are generally the main contact with patients in the community, it is important that people undertaking this role understand the legal powers and duties and patients' rights under the order. In some areas only AMHPs had attended training on CTOs.

## Setting conditions for CTO patients

In some cases, CTO patients are made subject to conditions that are not sufficiently clear. For example, a condition that a patient was "not to abuse alcohol" contained no definition of what

would amount to abuse. CQC has also heard of very prescriptive but unenforceable conditions:

BB One of our drop-in centre users has a CTO condition not to drink more than three pints of beer a week. Who's going to enforce that? It's ridiculous, how can you say that to a man in his 50s, who's a social man and likes to go to the pub with his friends? DD

### Service user subject to a CTO

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While it may be appropriate to set conditions relating to lifestyle decisions, CQC would expect to see evidence of these having been discussed and agreed between patients and the care team through the care planning. This would not only comply with the Code of Practice's general principles and general expectations about modern service delivery (including CQC's essential standards of safety and quality), but would also ensure that the conditions were understood and meaningful to the patient subject to them.

BB Conditions for CTO or conditional discharge are still part of the shared pathway – no decision about me without me – and you should have a real say in what conditions they make for you. Services should realise this. DD

### Service user detained under section 47/49

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CQC has seen examples where this approach is being taken. One Mental Health Act Lead stresses in training to consultants in the trust that “conditions should be seen as the doctor’s view of what the patient needs to do to stay well and in the community and they should be negotiated, as much as possible, with the patient”, and reminds consultants that breaking a condition (other than the mandatory conditions of giving access to health professionals) is not, in itself, grounds for recall to hospital.<sup>152</sup>

It is important that both professionals and patients realise the limits of the law in this respect, to avoid unlawful exercise or threat of recall, but it seems widely misunderstood. CQC has heard reports of responsible clinicians being criticised by Tribunal members for not recalling a CTO patient who breaches a non-mandatory condition, and there seems to be a wide perception among CTO patients that, for example:

BB CTO is a section 3 in the community – they can have you back in hours. You can be recalled if your depot appointment is at 2 o’clock and you don’t turn up, that’s all it takes. DD

### Service user subject to a CTO

CQC has also noted some particularly restrictive conditions that may amount to deprivation of liberty. In one case, a patient was required to reside at a particular care home as a condition of his CTO. At that home, he was required to keep a night-time curfew starting from 9.30 pm and “for risk reduction to self and others” during the day was not allowed unsupervised access to his room, which was locked for this purpose.

MHA Commissioners and some Tribunal members expressed their disquiet that CTOs have been used to enforce conditions of residence in care homes that may amount to a deprivation of liberty. In 2009 CQC noted that this was how supervised discharge (the forerunner of CTO) sometimes appeared to have been used.<sup>153</sup> It is

similarly unclear over the extent to which this is a lawful exercise of power under the CTO regime. The matter could usefully be addressed in the next edition of the Code of Practice.\*

## Discharge from a CTO

From its introduction in November 2008, there have been 14,295 recorded uses of CTO (see table 6 above).\*\* Of these, 3,509 (25%) resulted in revocation, where the patient returned to hospital as a detained patient, and 3,922 (28%) were recorded as discharged from the CTO, and therefore from all powers of the MHA.

Data on appeals against CTO to the First-tier Tribunal (Mental Health) shows that patients are unsuccessful in appealing their CTO status in 84% of cases that proceed to a hearing (TABLE 7). This is a much higher rate of unsuccessful appeals than is experienced by detained patients, 65% of whose hearings do not lead to discharge. In part, this may be explained by the higher proportion of automatic referrals made to the Tribunal in the case of CTO patients.

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\* For current discussion of deprivation of liberty and CTO, see *Mental Health Act Code of Practice* (2008), para 28.7 *et seq*. This discusses deprivation of liberty in relation to patients entering a care home while subject to CTO, but not in relation to residence in such a care home as a condition of CTO.

\*\* It is likely that some patients have been subject to CTO on more than one separate occasion during this time, so it cannot be assumed that the total number of CTOs implemented equates with a total number of patients. Similarly, although there have been 5,107 incidences of recall to hospital since the introduction of CTO, it is not known how these incidences are spread across CTO use: some patients may have been recalled to hospital several times while subject to a particular CTO.

**TABLE 7****Appeals against CTOs to the First-tier Tribunal (Mental Health), 2010/11 to 2011/12**

	2010/11	2011/12
Applications	3,284	3,901
Withdrawn applications	0	713
Hearings	2,457	3,272
Discharges by Tribunal	112	161
No discharge by Tribunal	2,048	2,740

Source: Tribunal secretariat

A common concern of some patients – and some professionals – is the lack of clarity as to when a CTO will be deemed to have served its purpose so that it can end:

BB I just want to know how to get off a CTO – mine's just been renewed again – they say it's working. I made the biggest mistake of my life – I said to my doctor that the CTO saved my life. The worst thing I ever said, but I meant it at the time – for a period of time it actually did. But now I wish I could take that back, now how the hell do I get off it? DD

**Service user subject to a CTO**

In one trust, care co-ordinators told CQC that a CTO would be ended “if it was evident that it wasn't suitable for someone”, but in such circumstances the patient would be more likely to return to detention in hospital than have all powers of the Act lifted. Given that the measurement of whether a CTO was suitable would be whether a patient was settled and engaged with treatment, this creates something of a double-bind in terms of discharge criteria, as it is not clear how a patient could ever demonstrate that they were ready to remain in the community without being subject to a CTO.

On a CTO visit in a rural area in October 2011, staff and patients raised concerns about the lack of clarity around criteria for discharge from a CTO. AMHPs expressed this as their one reservation over the use of CTOs. AMHPs are required to seek the least restrictive alternative, but some patients that they agree to put onto a CTO as a means of a structured exit from hospital have now remained under the power for long periods of time. CQC was pleased to see that the trust was considering this issue and that professionals were thinking about how, at review, it may be possible to identify for patients what they need to do in order to be discharged from a CTO.

# Conclusions: Recommendations and next steps

The priority given to mental health by the Government will be helpful in raising the profile of these issues and bringing a new impetus to the development of services in ways that reflect the vision of No Health without Mental Health.

The implementation framework for the national policy gives clear guidance to commissioners and providers of services on the actions that will support the expression of this vision in practice. NICE guidelines give further advice in relation to the treatment of specific conditions, as well as the involvement of people who use services in their care and treatment.

The policy context with supporting evidence base expects that people will recover from mental ill health. Where an individual's mental health problems persist, reasonable adjustments will be made in all relevant settings, under the requirements of equalities legislation, to ensure that people are supported to live as full and socially participative lives as possible.

Many of the findings and messages in this report are familiar from previous years. It is with great regret that CQC notes that there are themes that recur year on year and paint a picture of practice in some areas of mental health provision that is a far cry from the policy vision. Yet it is clear from the excellent practice that CQC observes in some providers, that the policy vision is not an unrealistic one. These examples of excellent practice are important in highlighting what can be done and what organisations who fail to provide good care could do.

CQC therefore intends to strengthen the priority it gives to the regulation and monitoring of mental health services in the coming year. Mental health services must address the practice implications of parity and the recovery ethos enshrined in national policy. In particular CQC expects to see change in the following areas of recurring concern in the care and treatment of people subject to the Act:

- 1. Care planning should have clear statements about how a person is to be helped to recover, and follow guidance set out in the national Care Programme Approach. Plans should focus on individual needs and aspirations, involving patients at all stages so as to reflect their views and individual circumstances.** Care planning should be multidisciplinary. CQC recognises that on occasion treatment and care decisions can not always reflect what the patient wants. However, within these constraints, every effort should be made by providers to involve people in their own care, treatment and recovery. From a patient's position there should be "no decision about me, without me".
- 2. Hospitals should continually review their policies, procedures and practice to ensure there are no 'blanket rules' that cut across treating each person as an individual with rights to autonomy and dignity.**

3. **Clinical staff must be appropriately trained in assessing and recording whether the patient has mental capacity to make decisions and whether they consent to treatment. Ongoing dialogue with the patient is essential.** This conversation or dialogue should consider what treatment a person prefers and also how a person would like to be treated in the future (advance planning).

## Recommendations

1. **Policy makers** must consider the reasons why there are rising numbers of people subject to the Act and develop an appropriate policy response.
2. **The Boards of mental health trusts, independent providers of mental health care, and community trusts** are responsible and accountable for the quality of care people receive. They must drive the changes needed in their organisations. In particular they need to recognise and promote good practice and ensure that robust mechanisms are in place to understand individuals' experience of their services. CQC reminds providers of their own duties to monitor how they use powers derived from the Act (see the Code of Practice) and their duties under the Health and Social Care Act 2008 to demonstrate how they have learned lessons from practice and have made consequent improvements. This is an area that CQC will focus on in the next 12 months in its regulatory activity.
3. **The NHS Commissioning Board, local authorities, clinical commissioning groups and specialist commissioners** must commission services that guarantee a person's dignity, recovery and participation. Clinical commissioning groups and local authorities must ensure that local needs assessments for community services and commissioned models of care are informed by an understanding of their statutory duties under the Act and by the experiences of people who use services.

## What CQC will do next

In line with its proposed strategic direction over the next three years, CQC's intention is to strengthen how it meets its unique responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated strong support for this intention and for CQC establishing itself as an effective regulator of the care and treatment of people with mental health problems.

CQC will:

1. Increase the involvement of people who use services in Mental Health Act monitoring work, to inform CQC's understanding of service quality and of risks to the rights of vulnerable individuals.
2. Work with Healthwatch England to develop CQC's understanding of the experiences of people who use health services while subject to the powers of the Act.
3. Focus specifically on the areas of required improvement highlighted in this report. CQC will hold providers to account for positively improving in these areas through the different regulatory approaches at its disposal.
4. Continue to give a focus to good practice in order to promote improvement across the sector.

# Appendix A:

## Ethnicity and use of the Act

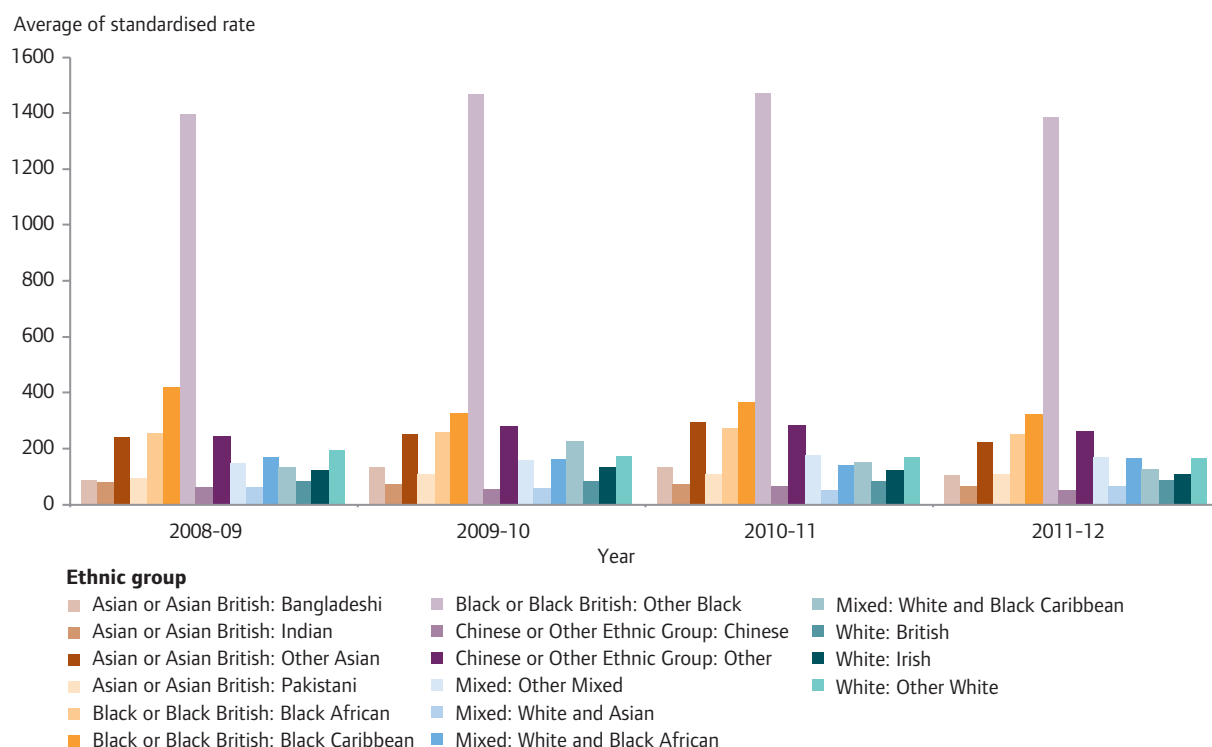
Figures 28 and 29 summarise the use of the Act by the ethnicity of people detained in adult mental health services, from data available from the Mental Health Minimum Data Set (MHMDS) quarterly data.\* Figure 28 shows all groups;

figure 29 shows the same data but without the Other Black category, to make it easier to see the variation.

\* These figures for 2011/12 have been sourced from aggregated quarterly MHMDS data and are provisional figures. Final data for 2011/12 is due to be published by the Health and Social Care Information Centre in February 2013. It should be noted that MHMDS currently has little coverage of independent hospitals and excludes data from NHS learning disability services, NHS child and adolescent mental health services and NHS general acute hospitals.

**FIGURE 28**

Use of the Act for detained patients from Black and minority ethnic groups, 2008/09 to 2011/12

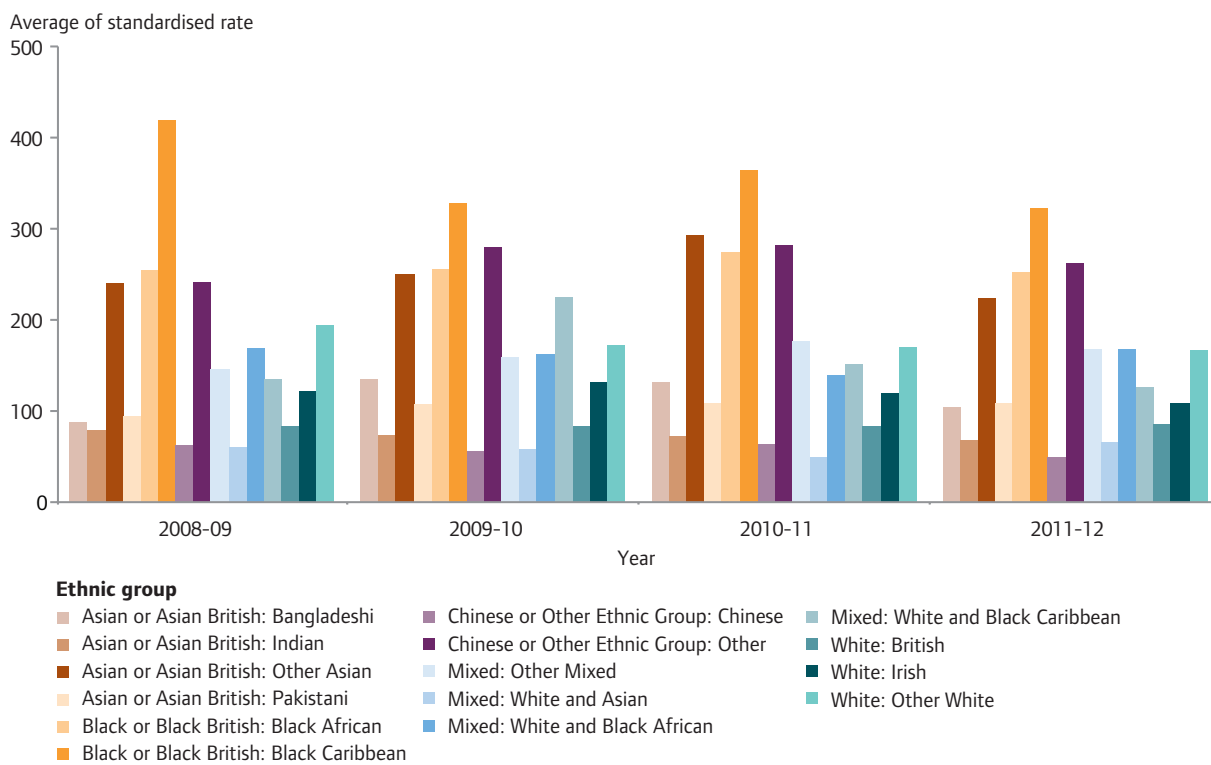


Source: Mental Health Minimum Data Set



**FIGURE 29**

**Use of the Act for detained patients from Black and minority ethnic groups, 2008/09 to 2011/12 (excluding Other Black category)**



Source: Mental Health Minimum Data Set

The graphs show the standardised rates of admission and detention (event) from the MHMDS.

A standardised event ratio is essentially a comparison of the number of the observed events in a population with the number of expected events if the age-specific event rates were the same as a standard population. It is expressed as a ratio of observed to expected event, multiplied by 100.

A standardised event ratio of 100 implies that the event rate is the same as the standard event rate. A number higher than 100 implies an above average event rate, whereas a number below 100 implies below average event occurrence.

The graphs should be read together with table 8, which is based on the standardised event ratio and the confidence intervals, as a standardised event ratio can only be described as high if both the upper and lower limits of the confidence interval are above 100, or low if both upper and lower limits are below 100.

**TABLE 8****Use of the Act for people from Black and minority ethnic groups, 2011/12**

<b>Ethnic group</b>	<b>Standardised ratios voluntary patients</b>	<b>Standardised ratios detained patients</b>
White British	98.42	85.62
White Irish	117.95	107.32
Other White	132.47	165.60
White and Black Caribbean	98.96	125.81
White and Black African	87.29	166.50
White and Asian	58.01	64.82
Other Mixed	121.06	167.41
Indian	40.70	67.37
Pakistani	66.92	108.16
Bangladeshi	59.16	103.90
Other Asian	159.94	223.48
Black Caribbean	152.55	321.81
Black African	117.37	251.59
Other Black	648.71	1386.40
Chinese	26.68	48.30
Other ethnic group	183.13	261.86

Source: Mental Health Minimum Data Set

Numbers shaded darker blue are significantly lower than expected (that is, the figures and their confidence interval are all below 100); numbers shaded lighter blue are significantly higher than expected (that is, the figures and their confidence interval are all above 100).

TABLE 9

SOAD visits: difference in ethnicity between general, inpatient and CTO populations, November 2008 to August 2011

Ethnic group	Populations by ethnic group in England		
	Whole population estimates 2009	Inpatient population 2010	CTO population 2008-11
	%	%	%
<b>White</b>	<b>87.46</b>	<b>81.30</b>	<b>71.62</b>
British	82.78	75.09	65.62
Irish	1.08	1.66	0.85
Other White	3.59	4.54	5.16
<b>Mixed</b>	<b>1.39</b>	<b>2.92</b>	<b>3.47</b>
White and Black Caribbean	0.58	1.37	0.74
White and Black African	0.25	0.46	0.33
White and Asian	0.56	0.45	0.35
Other Mixed	0.45	0.65	2.06
<b>Asian or Asian British</b>	<b>6.12</b>	<b>4.87</b>	<b>7.82</b>
Indian	2.73	1.75	1.80
Pakistani	1.92	1.45	1.73
Bangladeshi	0.74	0.66	0.75
Other Asian	0.73	1.01	3.54
<b>Black or Black British</b>	<b>2.94</b>	<b>9.68</b>	<b>15.02</b>
Black Caribbean	1.18	5.32	6.00
Black African	1.52	3.16	4.85
Other Black	0.24	1.20	4.17
<b>Other ethnic groups</b>	<b>1.64</b>	<b>1.23</b>	<b>2.07</b>
Chinese	0.85	0.26	0.34
Any other ethnic group	0.80	0.97	1.74
<b>Totals</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>

Source: Adapted from Stray M, *A Quantitative Study of Community Treatment Orders*, 2011<sup>154</sup>

TABLE 10

Difference in ethnicity by percentage of age and gender in inpatient and CTO populations in England, November 2008 to August 2011

			Percentage of population					
Sex:			Male					
Age group:			<18	18-24	25-49	50-64	65+	Total
Ethnic group	White	inpatient	77.24	69.90	70.84	82.97	93.78	77.81
		CTO	52.94	62.12	67.21	78.93	86.49	69.47
	Mixed	inpatient	2.76	6.50	4.58	2.11	0.58	3.42
		CTO	5.88	5.81	4.16	1.92	0.90	3.81
	Asian or Asian British	inpatient	8.97	7.98	7.30	4.28	2.36	5.78
		CTO	17.65	11.61	9.15	5.35	5.71	8.63
	Black or Black British	inpatient	8.28	13.32	15.65	9.45	2.89	11.65
		CTO	11.76	18.87	17.34	12.54	5.11	16.14
	Other ethnic group	inpatient	2.76	2.30	1.63	1.19	0.39	1.35
		CTO	11.76	1.60	2.14	1.25	1.80	1.95
	Total			100.00	100.00	100.00	100.00	100.00
			Female					
Ethnic group	White	inpatient	88.37	85.73	77.84	88.74	93.63	86.14
		CTO	85.00	71.67	68.31	83.73	87.68	75.48
	Mixed	inpatient	4.32	4.52	3.72	1.10	0.57	2.23
		CTO	0.00	5.56	3.63	1.38	2.11	2.88
	Asian or Asian British	inpatient	2.99	3.59	5.87	3.08	1.51	3.61
		CTO	10.00	5.00	8.61	4.04	2.76	6.38
	Black or Black British	inpatient	3.32	4.83	11.18	5.94	3.66	6.94
		CTO	0.00	15.00	16.99	8.73	5.83	12.98
	Other ethnic group	inpatient	1.00	1.33	1.39	1.14	0.64	1.07
		CTO	5.00	2.78	2.47	2.11	1.62	2.27
	Total			100.00	100.00	100.00	100.00	100.00

Source: Adapted from Stray M, *A Quantitative Study of Community Treatment Orders*, 2011

# Appendix B:

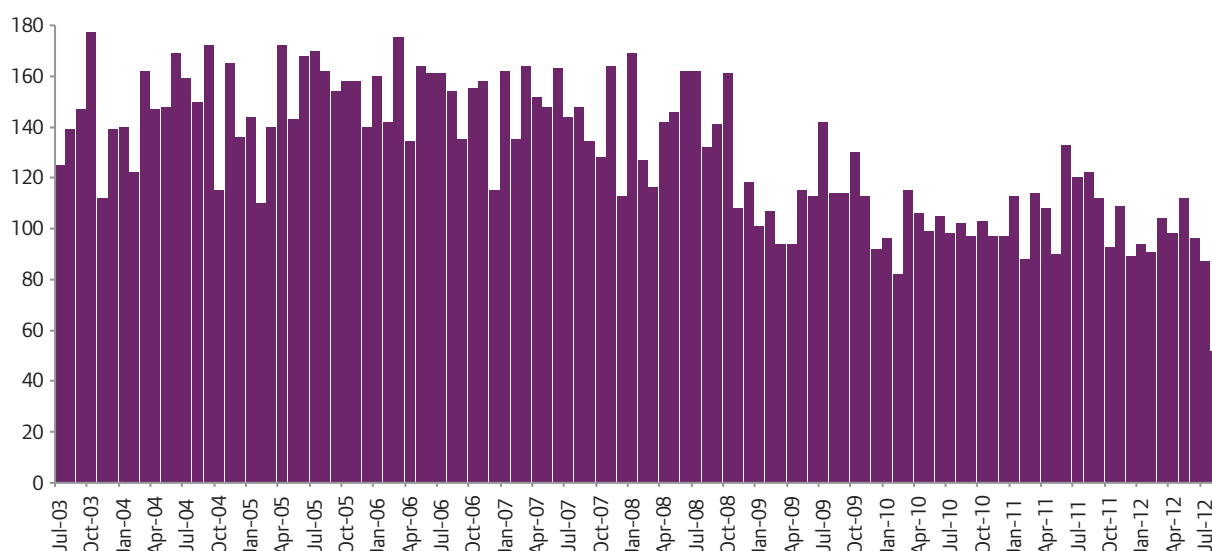
## Second opinions to consider electro-convulsive therapy (ECT)

The number of second opinions involving ECT shows an overall declining trend. This decline seems to include the change in law from November 2008 that removed SOAD powers to certify that ECT treatment should be given to detained patients who had capacity to refuse consent (**FIGURE 30**).<sup>155</sup> In the years leading up to that change, about a third of patients referred

for an ECT second opinion were described by their doctors to have capacity and be refusing consent,<sup>156</sup> and the numbers dropped by roughly that proportion at that time. The average annual number of ECT second opinions completed between 2004/05 and 2008/09 was 1,747; between 2009/10 and 2011/12 it was 1,256.

**FIGURE 30**

Completed second opinions involving ECT by month, July 2003 to July 2012



Source: CQC\*

\* Data collated from *completed* second opinions only (thus excluding cancelled requests), leading to variation from totals published in CQC, 2010, *Monitoring the use of the Mental Health Act in 2009/10*, p90 (figure 23). Includes second opinion requests where approval sought for both ECT *and* medication: these second opinions have been excluded from some other tables in this chapter.

The reduction in requests for SOAD consideration of ECT must be seen in the national context of ECT treatment. The decline in ECT use generally has been noted in research.<sup>157</sup> Researchers have suggested various reasons for this decline, including the publication of more restrictive NICE

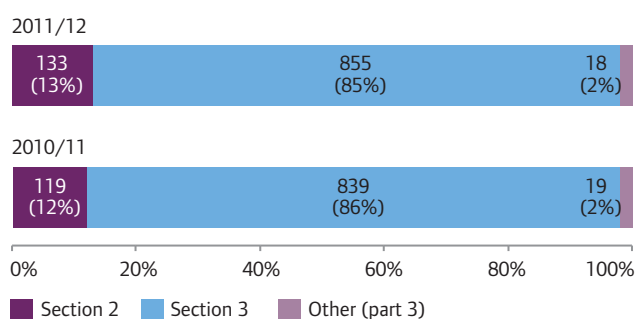
guidelines in 2003<sup>158</sup>; the availability of a greater variety of alternative antidepressants; patient resistance; falling numbers of inpatient beds<sup>159</sup>; and the reduction in ECT facilities.

## Patients receiving ECT second opinions

The majority of detained patients receiving a SOAD visit to consider the use of ECT are detained under section 3 of the Act, the renewable civil power to detain for treatment in hospital. In 2011/12, 85% of SOAD visits to consider ECT only were to patients detained under section 3 (**FIGURE 31**). However, 13% of visits in 2011/12 were to patients detained under the powers of section 2, a non-renewable power to detain for up to 28 days for assessment or for assessment followed by medical treatment.<sup>160</sup>

**FIGURE 31**

Completed second opinions considering ECT only, by detention power used, 2011/12



Source: CQC

In addition to the visits shown at figure 31, three SOAD visits to voluntary patients under the age of 18 who were being considered for ECT took place – two in 2010/11 and one in 2011/12. These are the first such visits undertaken by SOADs since the requirement for SOAD certification of ECT treatment for any patient aged below 18 years was introduced from 2008. All three patients were deemed to be consenting and treatment was authorised.

There were 10 SOAD visits to consider ECT treatment for detained patients under 18 years of age in 2010/11 and 2011/12, three of which resulted in some change to the treatment plan proposed.

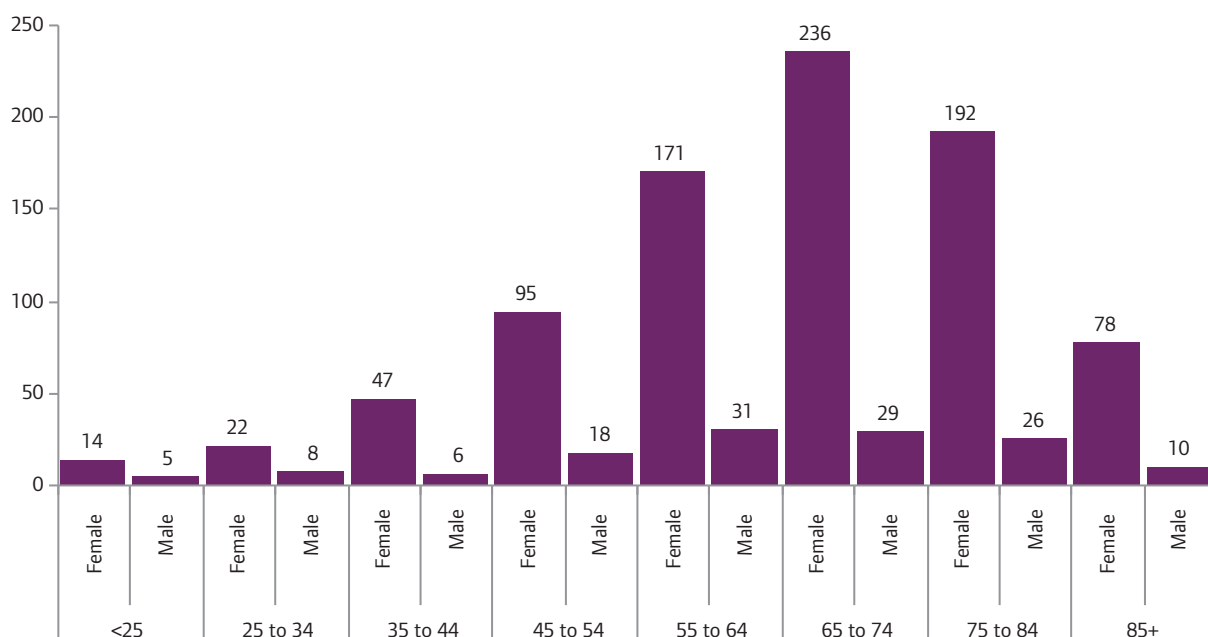
Figure 32 shows the age and gender of patients detained under sections 2 or 3 for whom second opinions considering ECT were completed. Male patients account for less than a third of the overall number, and the greater number of treatments are proposed for older patients. It does not include the 18 second opinions to consider ECT for patients detained under the criminal justice provisions of the Act\*, all but one of whom was male and whose average age was 46: a reflection of the general demographic of this group.

\* 17 patients under MHA s.37 or 37/41 (a court order for detention under the Act on conviction of an offence, with 7 subject to restriction orders), and one patient transferred to hospital from prison under s.48/9 of the MHA.



**FIGURE 32**

Completed second opinions considering ECT only, by gender and age of patients detained under sections 2 and 3, 2011/12



Source: CQC

## Use of urgent treatment powers prior to ECT second opinions

In 2011/12, over a quarter of patients for whom ECT second opinions were completed had already received at least one application of the treatment prior to the SOAD visit, using emergency treatment powers (**FIGURE 33**). In 2009/10 and 2010/11, over a third of patients referred for a second opinion received treatment on this basis before the SOAD visit.<sup>161</sup> Although it is not unusual for ECT treatment to be considered an emergency intervention to save life (principally when a patient with a depressive illness has stopped eating or drinking), these years' data show that a large proportion of patients continue to be denied the safeguard of a statutory second opinion before treatment commences.

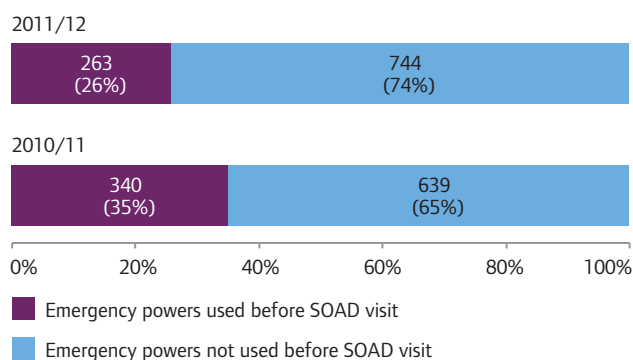
This is not a new problem: between 2004 and 2008, 23% of ECT second opinions were given for patients who had already received emergency treatment<sup>162</sup>, but it is disappointing that the proportion of patients receiving emergency ECT treatment prior to their second opinion remains higher than was observed prior to the change

in the law that narrowed the criteria for such treatment.<sup>163</sup>

**FIGURE 33**

Completed second opinions considering ECT only, 2010/11 and 2011/12

Were urgent treatment powers used to give treatments before the second opinion visit?



Source: CQC

## ECT treatment and CTO patients

During 2010/11 and 2011/12, CQC arranged eight SOAD visits (four in each year) to consider treatment plans involving both medication and ECT for patients on CTO. Six of the patients were women, two were men. Three patients were consenting to ECT, and five lacked capacity to give or refuse consent. Treatment was approved as appropriate in all cases.

From June 2012, the new Form CTO12 can be used by the clinician in charge of ECT treatment

to certify the consent to ECT treatment of CTO patients who are aged 18 years or over. However, the changes in the regulations do not alter the position that ECT treatment cannot be given to any patient who is not yet 18 (regardless of whether or not the patient is detained or subject to CTO) unless a second opinion appointed doctor has certified that the patient consents to ECT and that the treatment is appropriate on Form T5. CTO referrals for ECT second opinions to date have all been for patients aged over 18.

# Appendix C:

## Advisory Group

An external Advisory Group provided experience and expertise on the approach and scope of this Mental Health Act annual report. The group met three times in 2012, offered comment and advice on the themes and issues covered by the report, and reviewed the detailed draft.

CQC is grateful for the time, support, advice and expertise given to the report by the group. The members were:

- Lucy Butler, ADASS
- Julie Chalmers, Royal College of Psychiatrists
- Steve Chamberlain, Royal Borough of Kensington and Chelsea
- Alison Cobb, Mental Health Alliance
- Martin Coyle, Action for Advocacy
- Netta Hollings, Health and Social Care Information Centre
- Ian Hulatt, Royal College of Nursing
- Brenda James, Service User Reference Panel
- Matilda MacAttram, Black Mental Health UK
- Anne McDonald, Department of Health
- Claire Murdoch, Central and North West London NHS Foundation Trust
- Charles Saddler, Service User Reference Panel
- Genevieve Smyth, British Association and College of Occupational Therapists
- Nicola Vick, NHS London
- Sarah Yiannoullou, National Survivor User Network

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